

Statewide Universal Health Care Access Plans

Volume II
Supporting Materials

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State of Montana
Health Care Authority
Report to the Legislature
October 1, 1994

STATE OF MONTANA

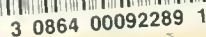
Statewide Universal Health Care Access Plans

Volume II

Supporting Materials

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Montana Health
Care Authority
Statewide
universal health
care access plans

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I. DEMOGRAPHIC INFORMATION

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1. MONTANA DEMOGRAPHICS

MONTANA POPULATION CHANGE

For Years 1980-2000

MONTANA	YR 1980	YR 1990	PROJECTED YR 2000
Total Population	786,690	799,065	866,670

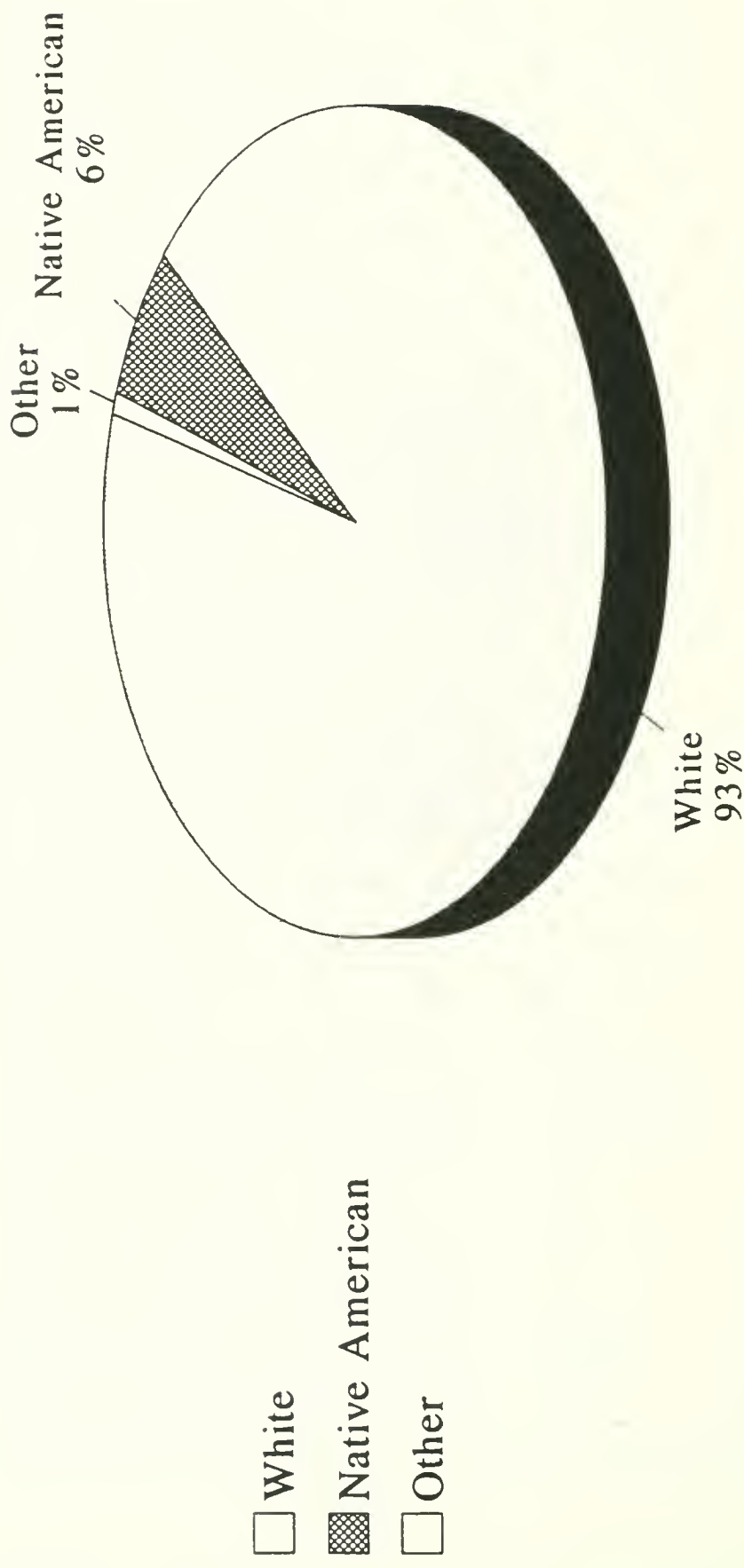
SOURCES: 1980 and 1990 U.S. Census and Projections for the Year 2000 from "NPA Data Services, Inc.
1992 Regional Economic Projections Series"

CHANGES IN AGE DISTRIBUTION OF MONTANA POPULATION					
Age Group	Year 1980 (in thousands)	Year 1990 (in thousands)	Percent Change 1980 - 1990	Year 2000 Projections	Percent Change 1990 - 2000
0 - 14	186.41	187.87	.78%	187.34	-.28%
15 - 24	149.15	100.77	-48.01%	132.90	31.88%
25 - 34	134.70	123.62	-8.96%	110.07	-10.96%
35 - 49	125.23	174.48	28.23%	196.90	12.85%
50 - 64	108.73	105.52	-3.04%	133.02	26.06%
65 +	84.72	106.61	20.53%	106.44	-.16%
Total	788.94	798.86	1.24%	866.67	8.49%

Source: NPA Data Services, Inc., 1992 Regional Economic Projections Series

ETHNIC BREAKDOWN

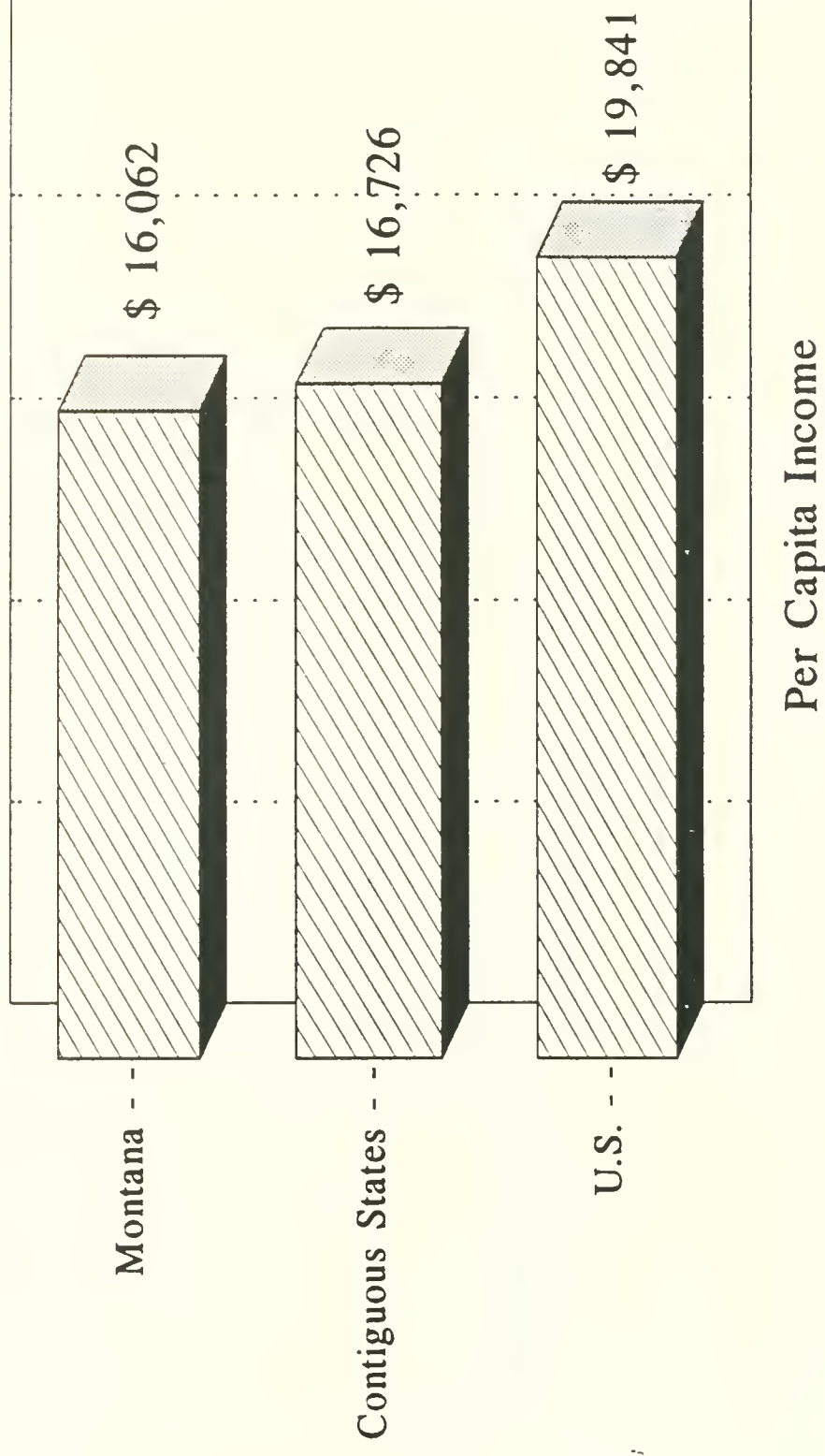
Montana



SOURCE: U.S. Census, 1990

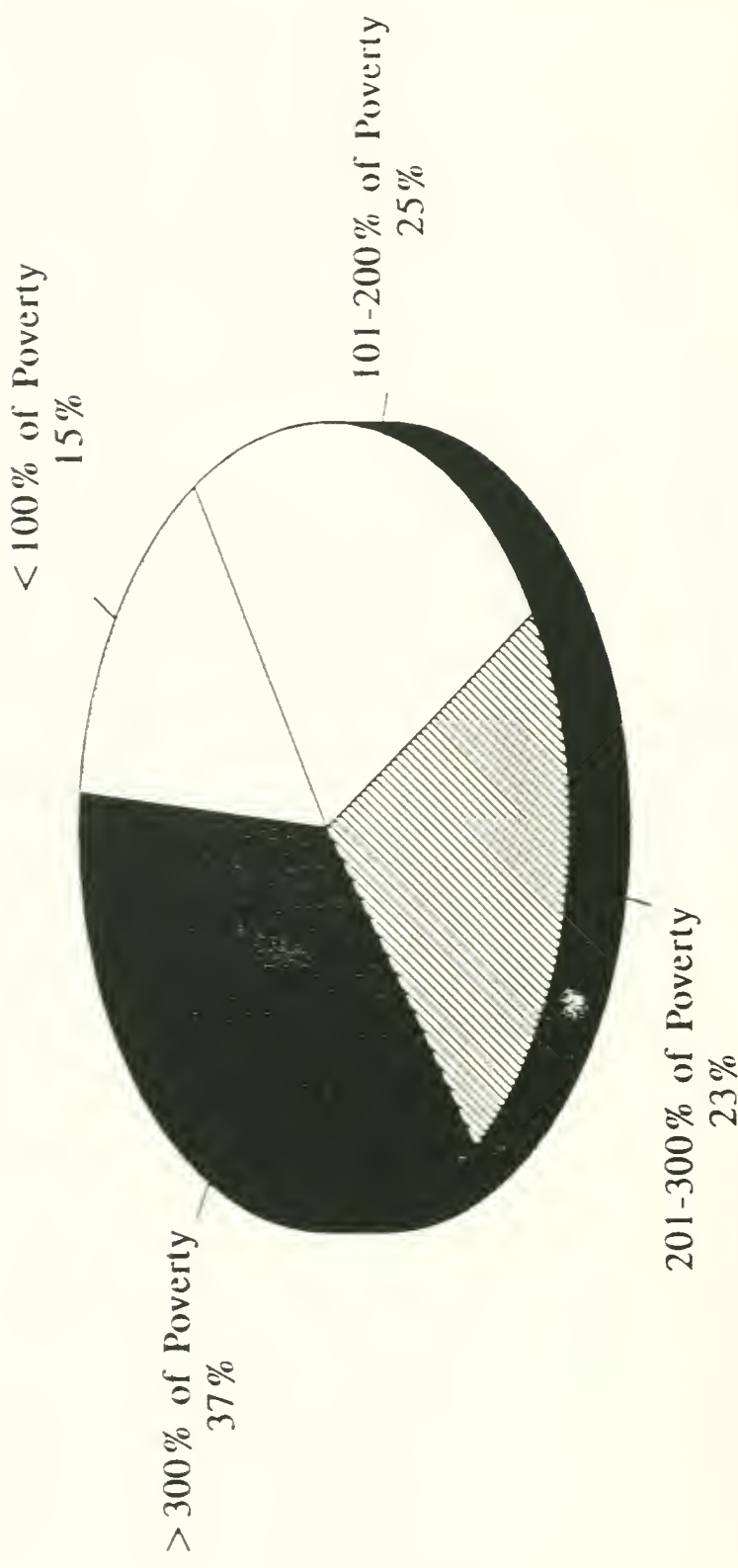
PER CAPITA INCOME

Montana vs. U.S. and Contiguous States



PERCENT OF MONTANANS IN POVERTY, 1992

By Poverty Status



Total Population: 824,682

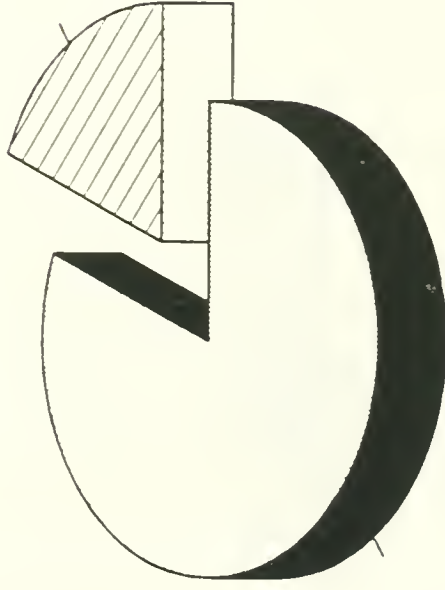
SOURCE: Health Systems Research, Inc. Analysis of Montana 1992-93 CPS

PERCENTAGE OF CHILDREN IN POVERTY

Based on Number of Children in Poverty/Total Number of Children

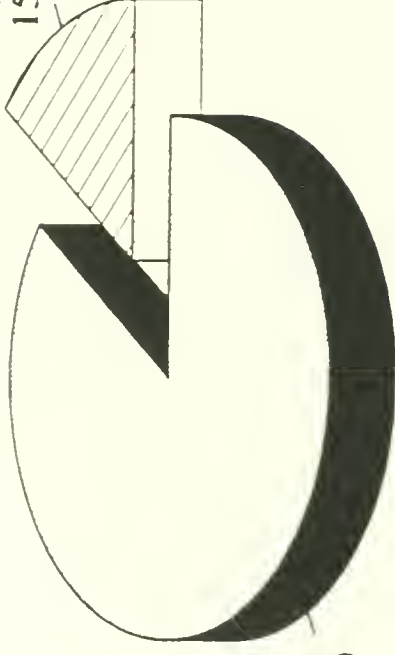
Ages 0 - 4



13,980
19%



Ages 5 - 17

29,257
15%

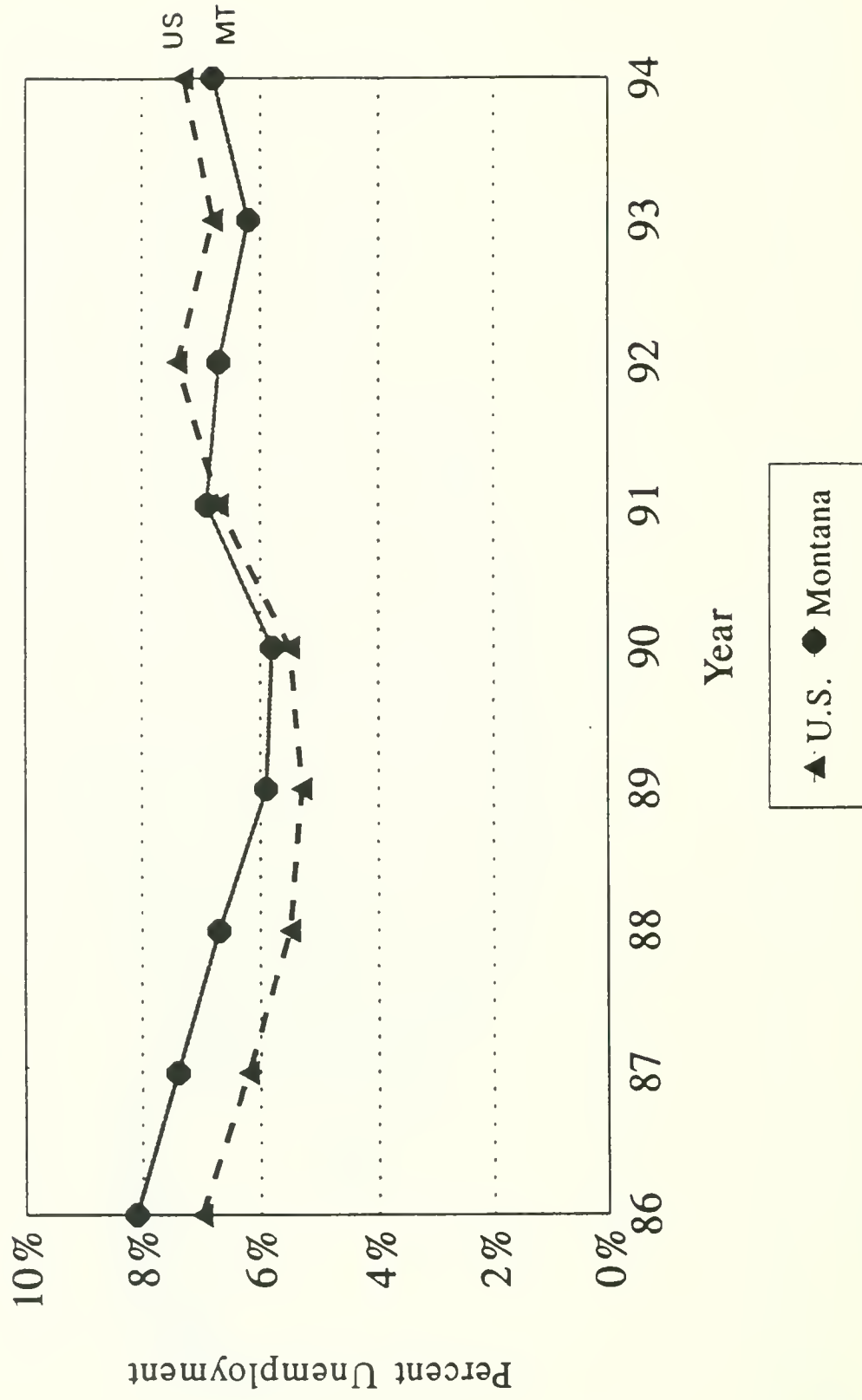


 Children in Poverty  Total Children

SOURCE: 1990 Census

ANNUAL AVERAGE UNEMPLOYMENT RATE - MT vs. US

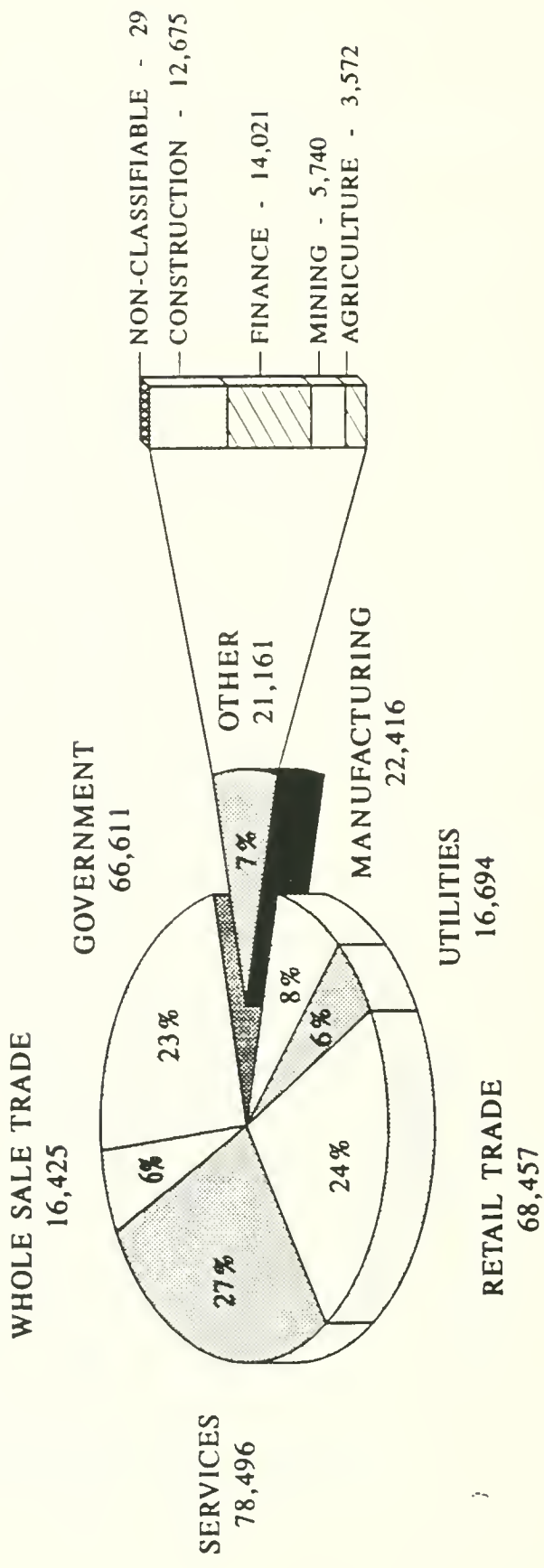
Years 1980 - 1994 (January)



2. CHARACTERISTICS OF MONTANA LABOR FORCE

MONTANA EMPLOYMENT BY MAJOR SECTOR

1992

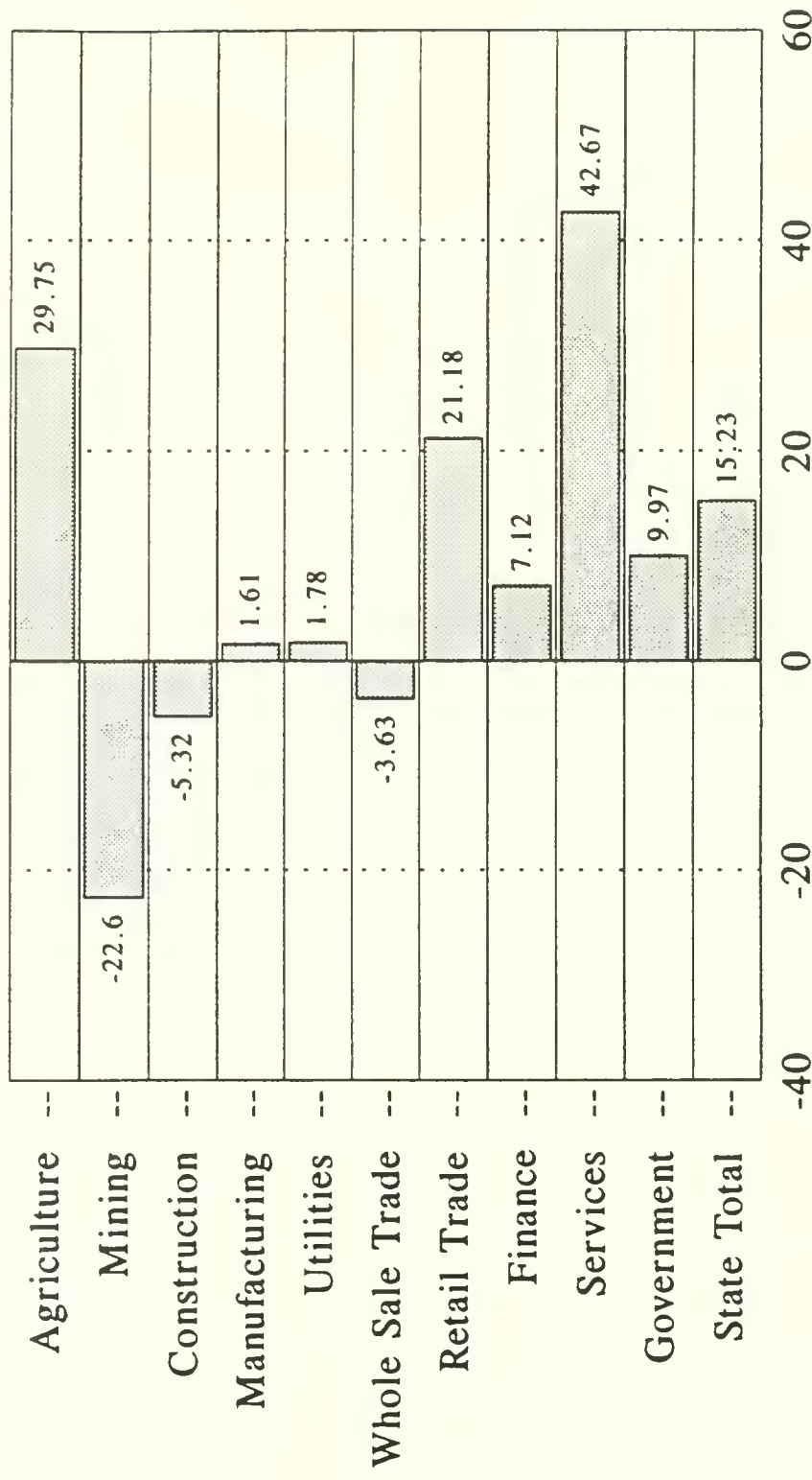


SOURCE: Montana Department of Labor and Industry

Health Systems Research, Inc.

CHANGES IN MONTANA LABOR FORCE

Percent Change in Employment by SIC 1983-1992



* Non-Classifiable not listed

SOURCE: Montana Department of Labor and Industry

CHANGES IN MONTANA LABOR FORCE

Percent Change in Employment by SIC 1983-1992

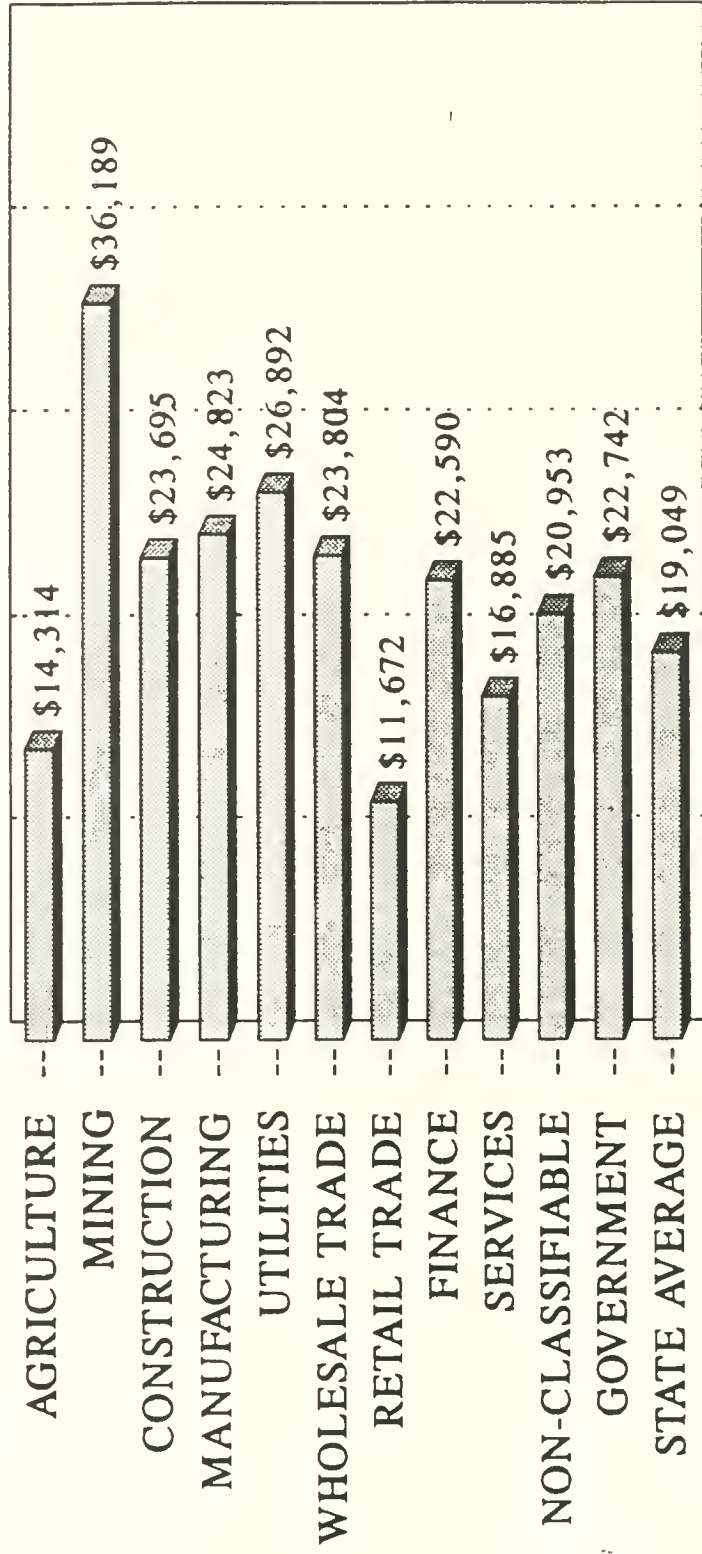
Montana	YR 1983	YR 1992	% Change
Agriculture	2,753	3,572	29.75
Mining	7,416	5,740	-22.60
Construction	13,387	12,675	-5.32
Manufacturing	22,060	22,416	1.61
Utilities	16,402	16,694	1.78
Whole Sale Trade	17,044	16,425	-3.63
Retail Trade	56,490	68,457	21.18
Finance	13,089	14,021	7.12
Services	55,020	78,496	42.67
Non-Classifiable	622	29	-95.34
Government	60,570	66,611	9.97
State Total	264,817	305,148	15.23

Source: Montana Department of Labor and Industry

AVERAGE YEARLY WAGE BY EMPLOYER TYPE

1992

Employment Sector



Average Yearly Wage

SOURCE: Montana Department of Labor and Industry

EMPLOYMENT AND WAGES BY FIRM SIZE

State of Montana

Firm Size (Employees)	Number of Firms	Number of Employees	Total Yearly Wages	Avg. Yearly Wage
< 4	15,611	27,993	\$424,907,205	\$15,179
5 - 9	4,623	29,922	\$462,113,309	\$15,444
10 - 19	2,680	35,410	\$580,397,192	\$16,391
20 - 49	1,751	50,952	\$886,255,285	\$17,394
50 - 99	537	35,688	\$672,581,750	\$18,846
100 - 249	267	38,937	\$760,681,365	\$19,536
250 - 499	80	26,421	\$626,566,732	\$23,715
500 - 999	47	31,180	\$688,267,409	\$22,074
1000+	21	34,394	\$909,586,084	\$26,446
Total	25,616	315,570	\$6,011,356,331	\$19,049

Source: Montana Department of Labor and Industry

3. SIZE AND CHARACTERISTICS OF MONTANA'S UNINSURED POPULATION

ESTIMATED SIZE OF UNINSURED POPULATION IN U.S., 1987

- Point-in-time estimate: 34-36 million
- Uninsured entire year: 24.5 million
- Uninsured part of the year: 23.3 million
- Uninsured at some time during year: 47.8 million

Source: Short, AHCPR, National Medical Expenditure Survey

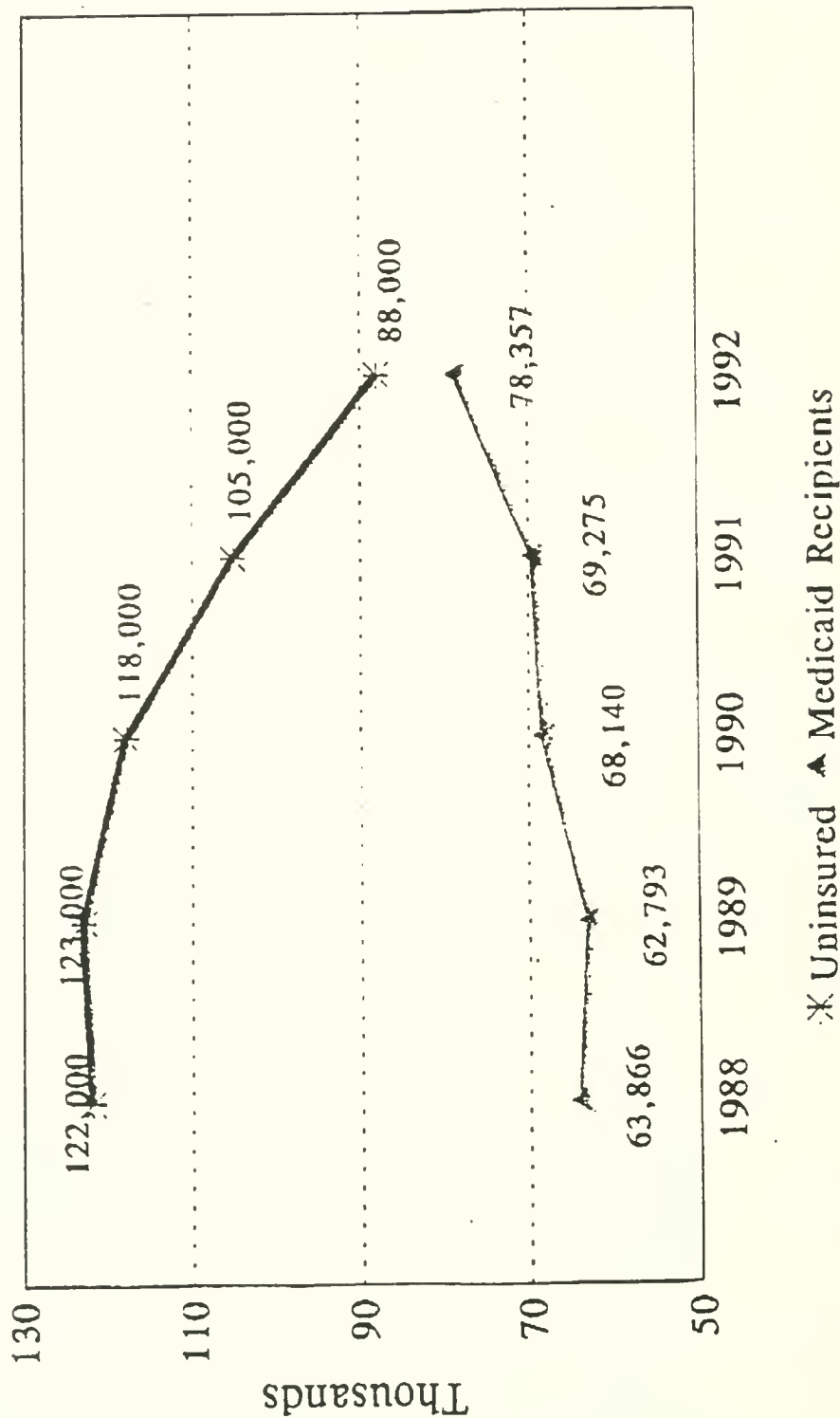
ESTIMATES OF THE UNINSURED POPULATION IN MONTANA

Age Group	Population (1990 Census)	Eastern Montana College Estimates		HSR Analysis of 1992-1993 CPS Estimates	
		Percent Uninsured	Number Uninsured	Percent Uninsured	Number Uninsured
< 6	72,280	---	---	10%	7,228
6 - 17	149,824	---	---	10%	14,982
18 - 24	70,011	35%	24,504	24%	16,803
25 - 34	123,070	25%	30,768	14%	17,230
35 - 44	126,756	13%	16,478	14%	17,746
45 - 54	82,306	12%	9,877	14%	11,523
55 - 64	68,321	12%	8,199	11%	7,515
65 +	106,497	5%	5,325	1%	1,065
Total	799,065	12%	95,150	12%	94,092

Source: The Eastern Montana College Poll: Health Care Issues, December 1992, and HSR Analysis of 1992-1993 Current Population Survey.

NUMBER OF UNINSURED AND MEDICAID RECIPIENTS

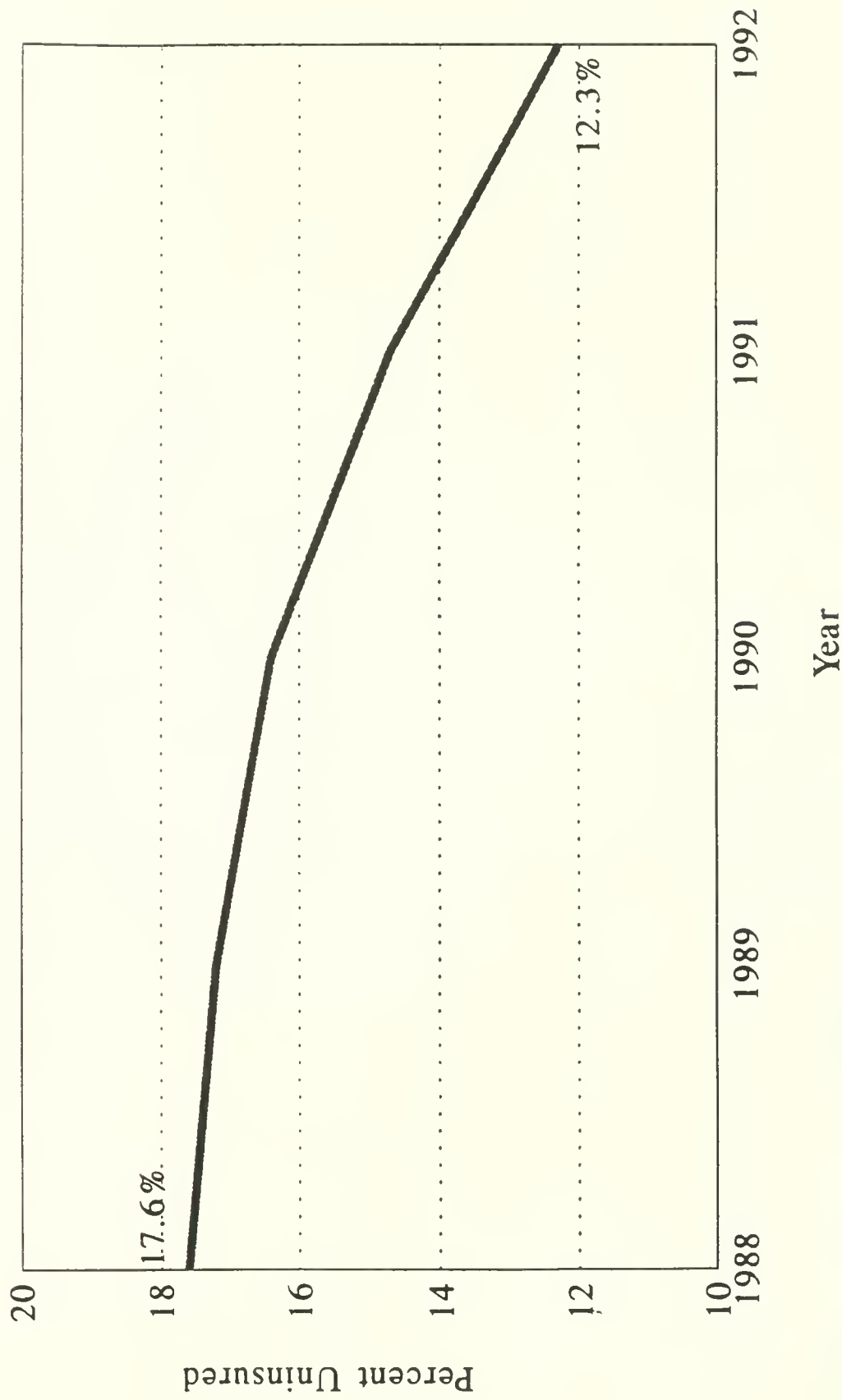
1988 - 1992



Source: EBRI's "Sources of Health Insurance and Characteristics of the Uninsured;" Department of Social and Rehabilitative Services "Medicaid Report;" Montana 2082 Data

PERCENT OF NONELDERLY POPULATION UNINSURED

1988 - 1992

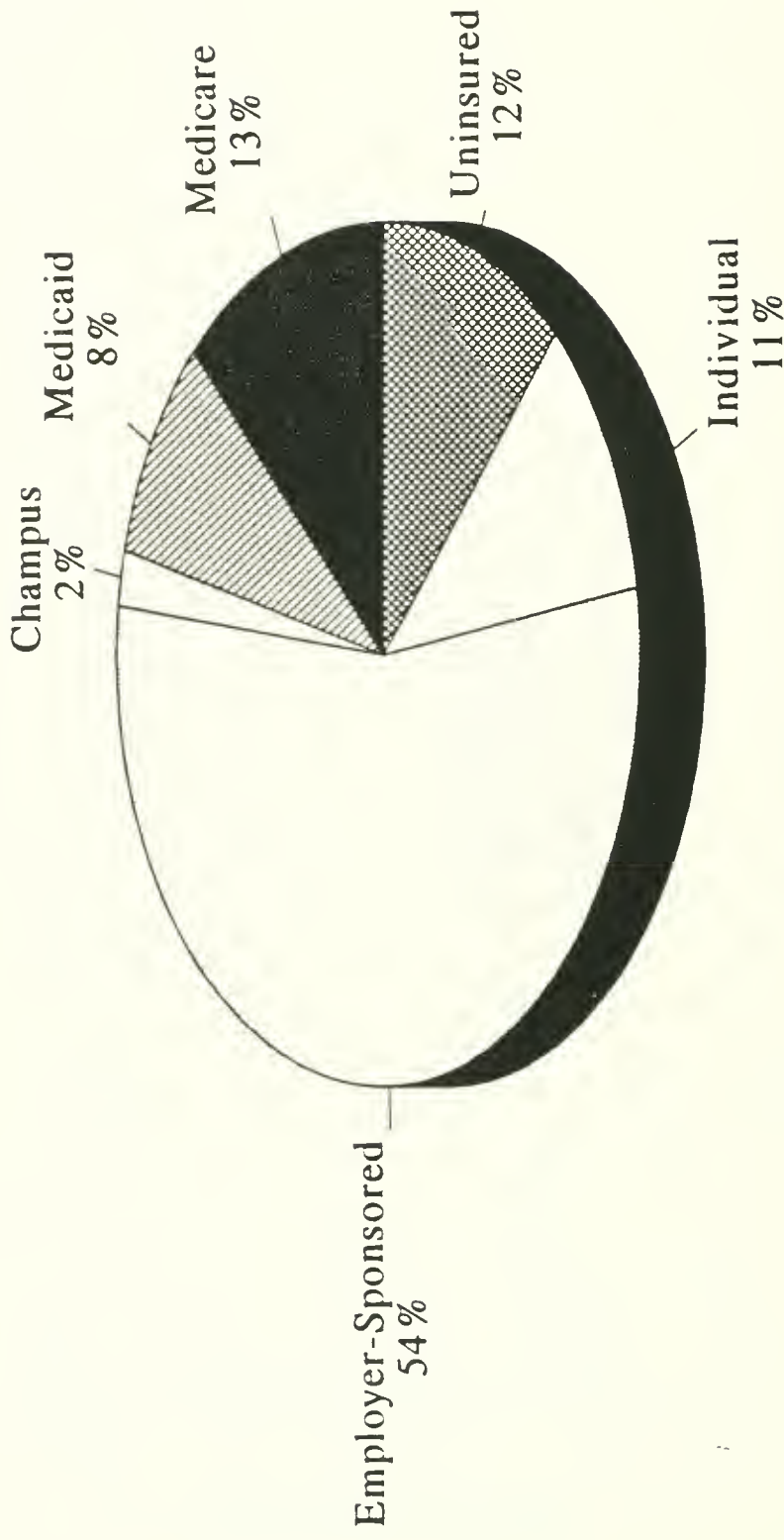


SOURCE: EBRI Special Report "Sources of Health Insurance and Characteristics of the Uninsured"

Health Systems Research, Inc.

MONTANA'S POPULATION

By Insurance Status

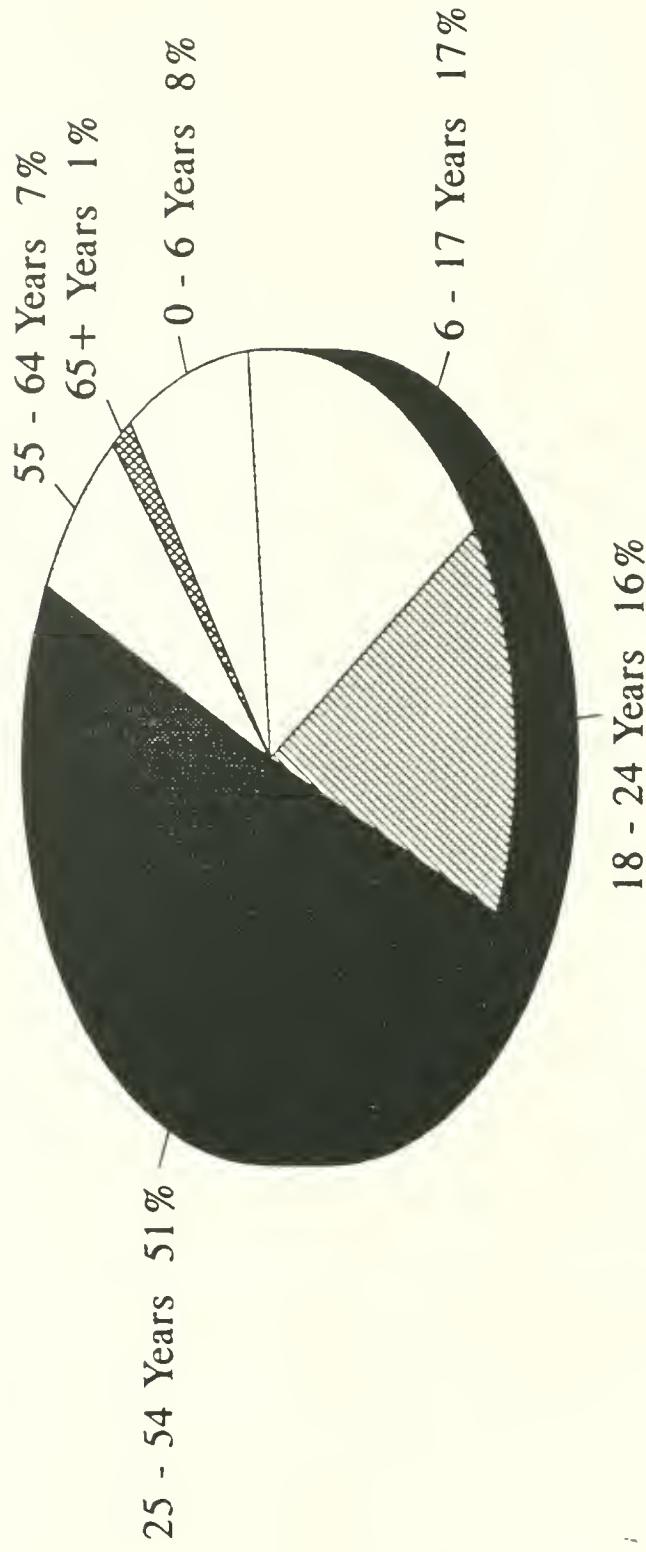


Total Population: 824,682

SOURCE: Health Systems Research, Inc. Analysis of Montana 1992-93 CPS

UNINSURED MONTANANS

By Age

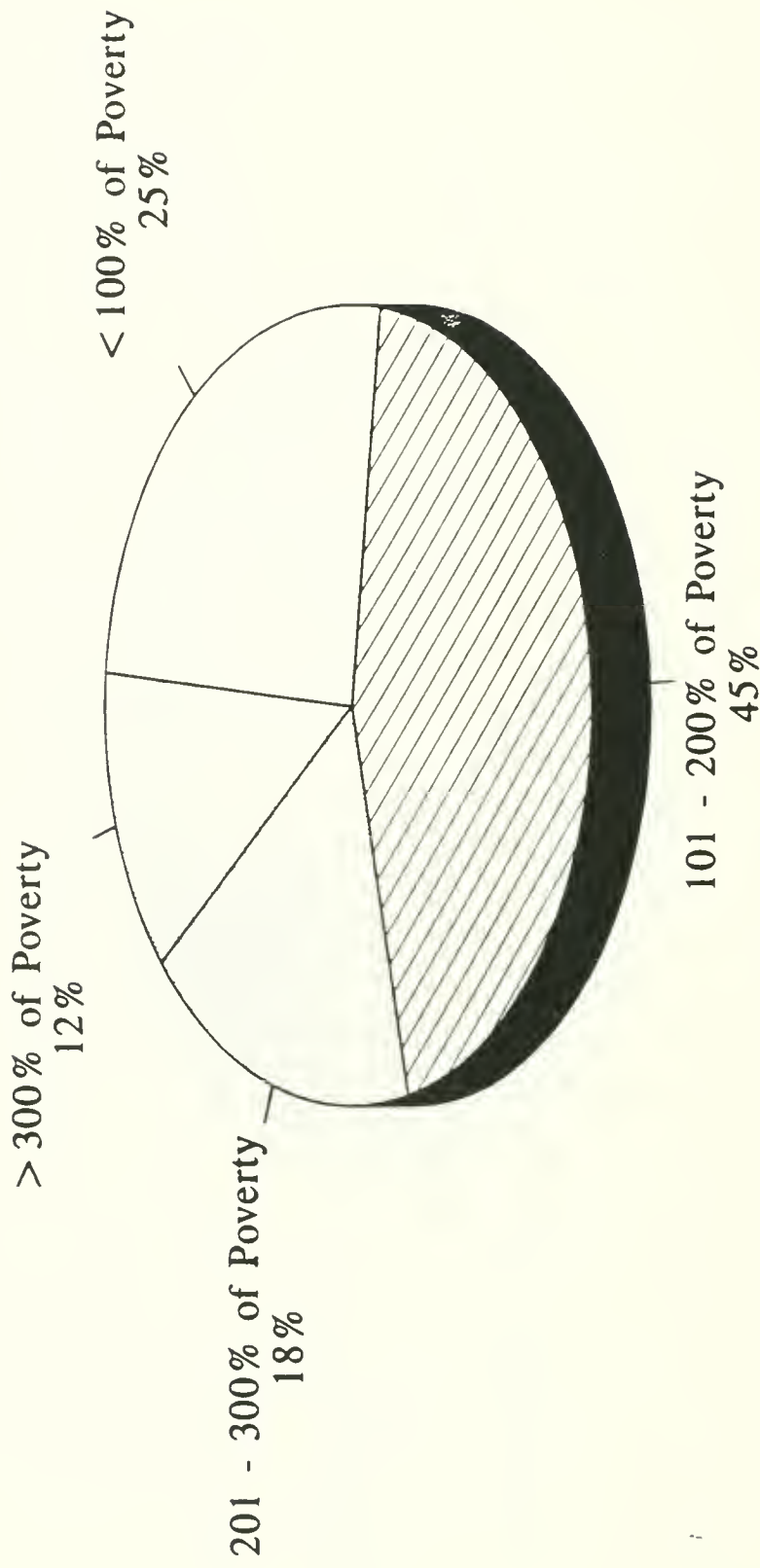


Total Uninsured Montanans: 94,867

SOURCE: Health Systems Research, Inc. Analysis of Montana 1992-93 CPS

UNINSURED MONTANANS

By Poverty Status

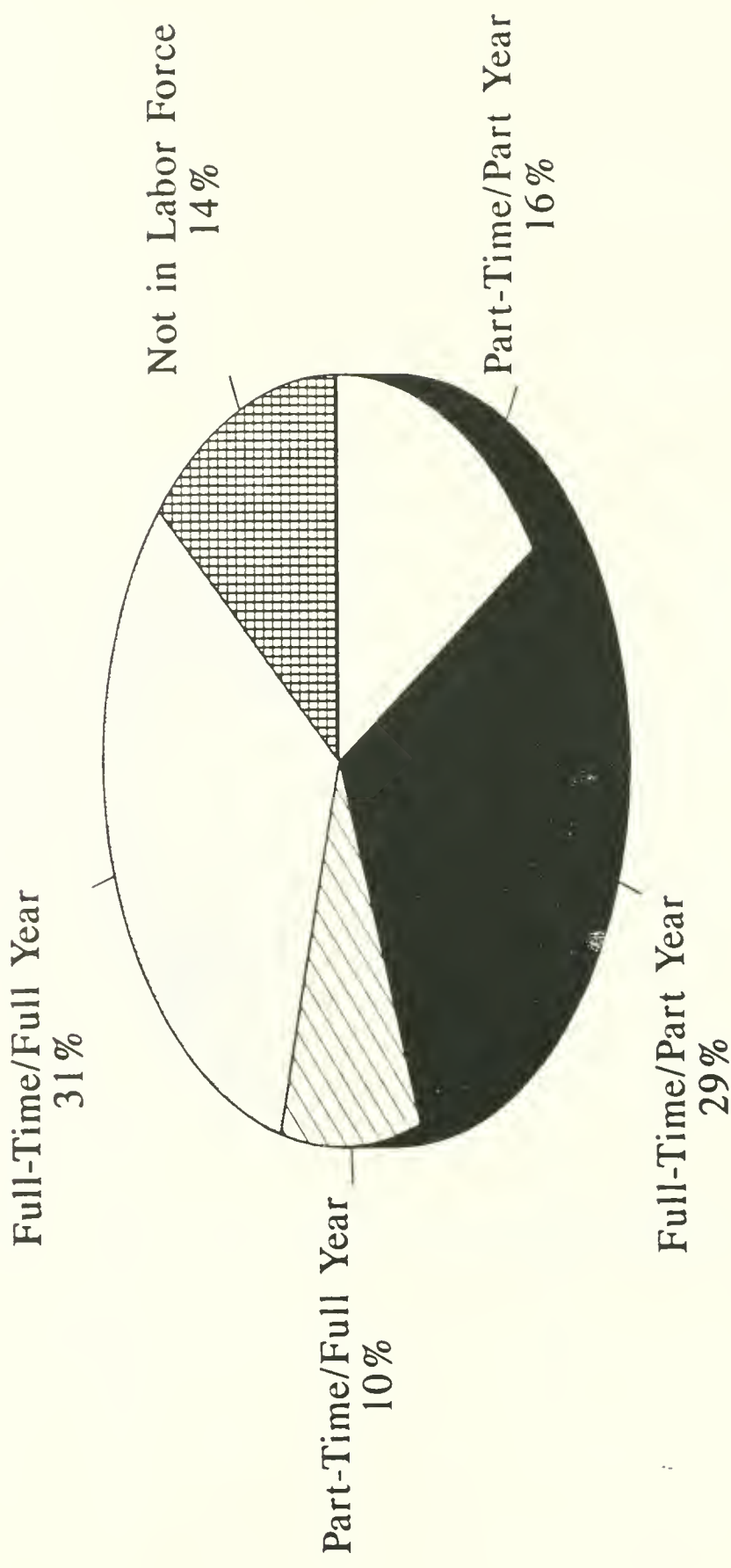


Total Uninsured Montanans: 94,867

SOURCE: Health Systems Research, Inc. Analysis of Montana 1992-93 CPS

EMPLOYMENT STATUS OF UNINSURED MONTANANS

Ages 18 - 64



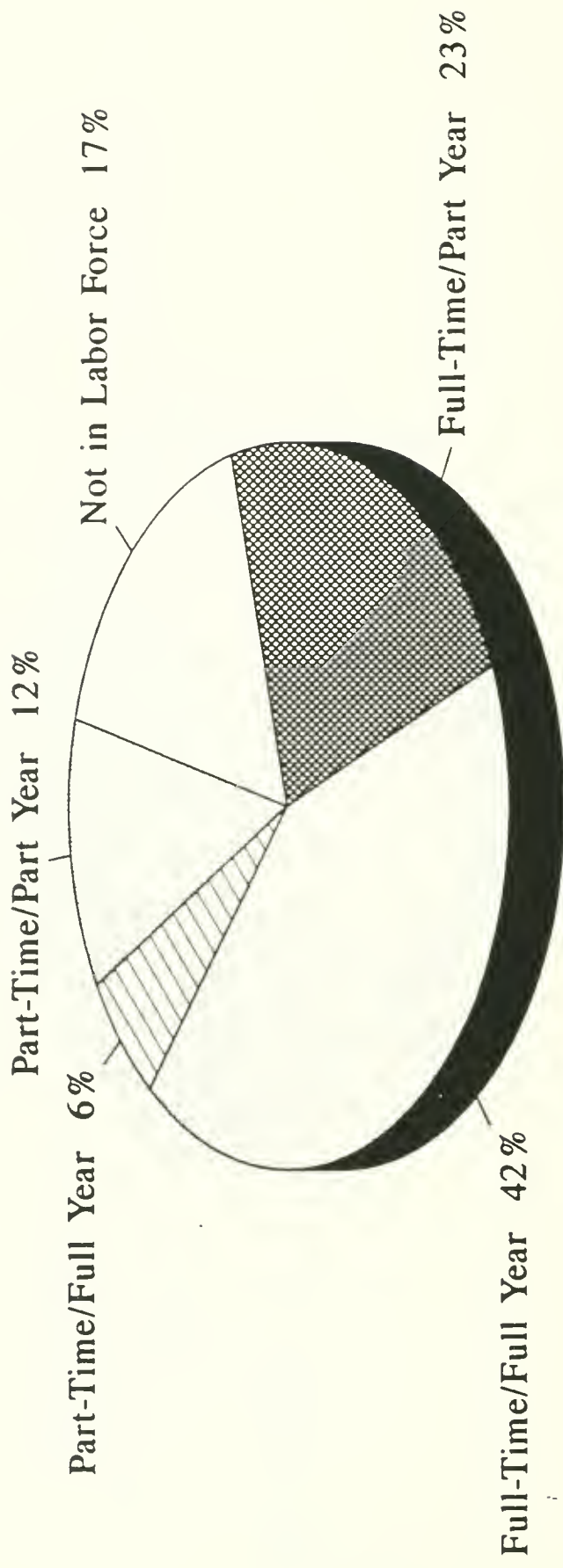
Total Uninsured Adults (18 - 64): 69,545

SOURCE: Health Systems Research, Inc. Analysis of Montana 1992-93 CPS

Health Systems Research, Inc.

DISTRIBUTION OF UNINSURED MONTANANS

By Employment Status of Family Head

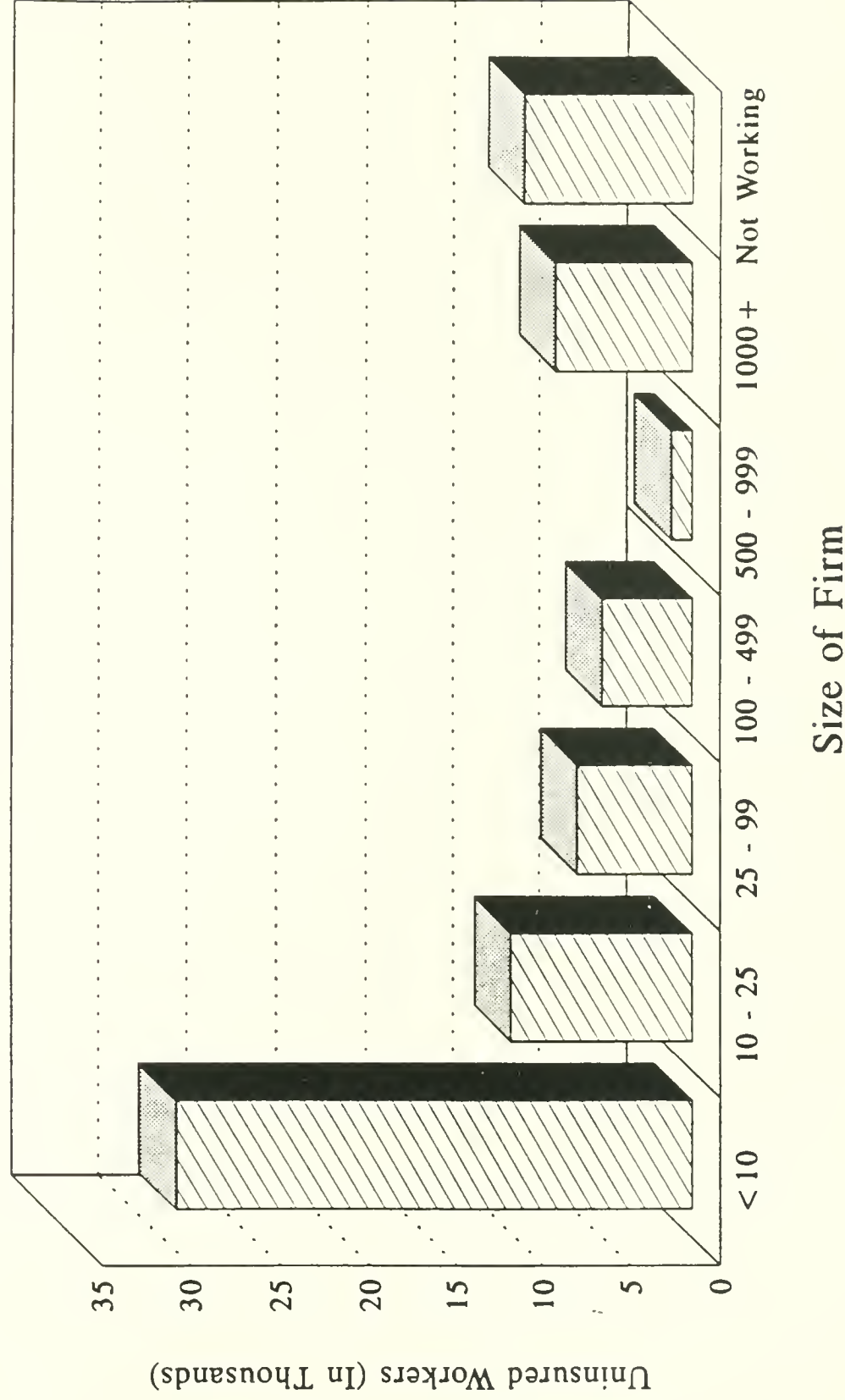


Total Uninsured Montanans: 94,867

UNINSURED WORKERS IN MONTANA (Ages 18 - 64)

By Size of Firm

N = 69,545



SOURCE: Health Systems Research, Inc. Analysis of Montana 1992-93 CPS

Health Systems Research, Inc.

4. MONTANA HEALTH CARE SPENDING AND UTILIZATION

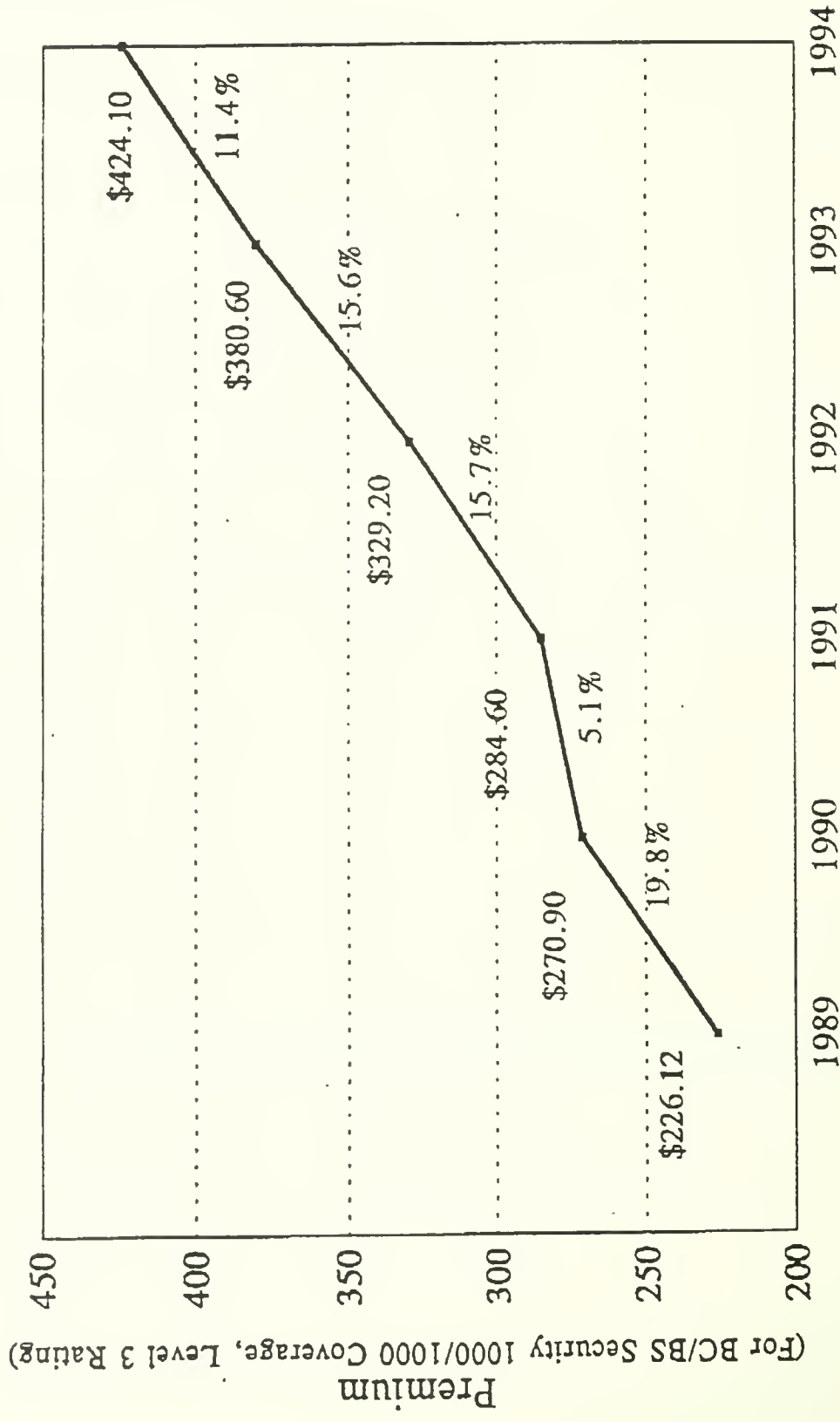
ESTIMATED HEALTH CARE SPENDING IN MONTANA 1992

SOURCES OF EXPENDITURES	TOTAL SPENDING (in \$ millions)	SOURCES OF DATA
Blue Cross/Blue Shield of Montana	\$212.9	Information from Blue Cross/Blue Shield Annual Report, includes expenditures for self insured plans administered by Blue Cross/Blue Shield.
All Other Private Insurers	\$191.4	Montana Insurance Department, direct premiums earned by companies licensed in the accident and health category.
Other Self Insured Plans	~\$150.00	Accurate aggregate information on health care spending by self-funded plans not available. Figure is very rough estimate of health expenditures made by self-funded plans not administered by Blue Cross/Blue Shield.
Other Private Sources	~\$60.00	Includes health-related philanthropic contributions and other non-patient care-related provider revenues. Estimate developed by applying percentage of total national expenditures for health services and supplies in 1991 attributed to this category 3.3% to estimate of total health care spending in Montana.
Out of Pocket Spending	\$358.00	Estimate derived by applying percentage of total natural expenditures for health services and supplies in 1992 attributed to this category 19.8% to the estimate of total health care spending in Montana.
Medicaid	\$248.2	Total Medicaid expenditures according to Montana Medicaid 2082's for 1992.
Medicare	\$328.0	Health Care Financing Administration, Office of Direct Reimbursement.
Workers' Compensation (Medical)	\$55.3	Estimate provided by Workers' Compensation Claims Assistance Bureau.
Automobile Insurance (Medical Coverage)	~\$21.0	Assumes 7.8% of auto insurance premiums are applied to medical claims, based upon Montana experience of State Farm Mutual.
Federal Spending		
Indian Health Service	\$87.2	Reported by Indian Health Service, Billings Region
Active Duty Military	\$5.2	Reported by Department of Defense
Veterans Administration	\$37.5	Reported by Veterans Administration

ESTIMATED HEALTH CARE SPENDING IN MONTANA 1992

SOURCES OF EXPENDITURES	TOTAL SPENDING (in \$ millions)	SOURCES OF DATA
CHAMPUS	~\$12.0	Based upon 1993 spending of \$13.3 million reported by CHAMPUS
Other State and Federal Spending (non-Medicaid)	~\$25.6	Based upon FY 1991 estimate of \$23.8 million prepared by the Health Services Division, Department of Health and Environmental Sciences. Updated by 7.5% to develop 1992 estimate.
Local Health Spending		
Health and Sanitation	\$1.7	Montana Biennial report, figure represents only local taxes specifically earmarked and does not include local health expenditures from general revenues.
Hospital Districts	\$1.2	Montana Biennial report, figure represents only local taxes specifically earmarked and does not include local health expenditures from general revenues.
TOTAL ESTIMATED SPENDING STATEWIDE	\$1,795.20	
Data compiled by Health Systems Research, Inc.		

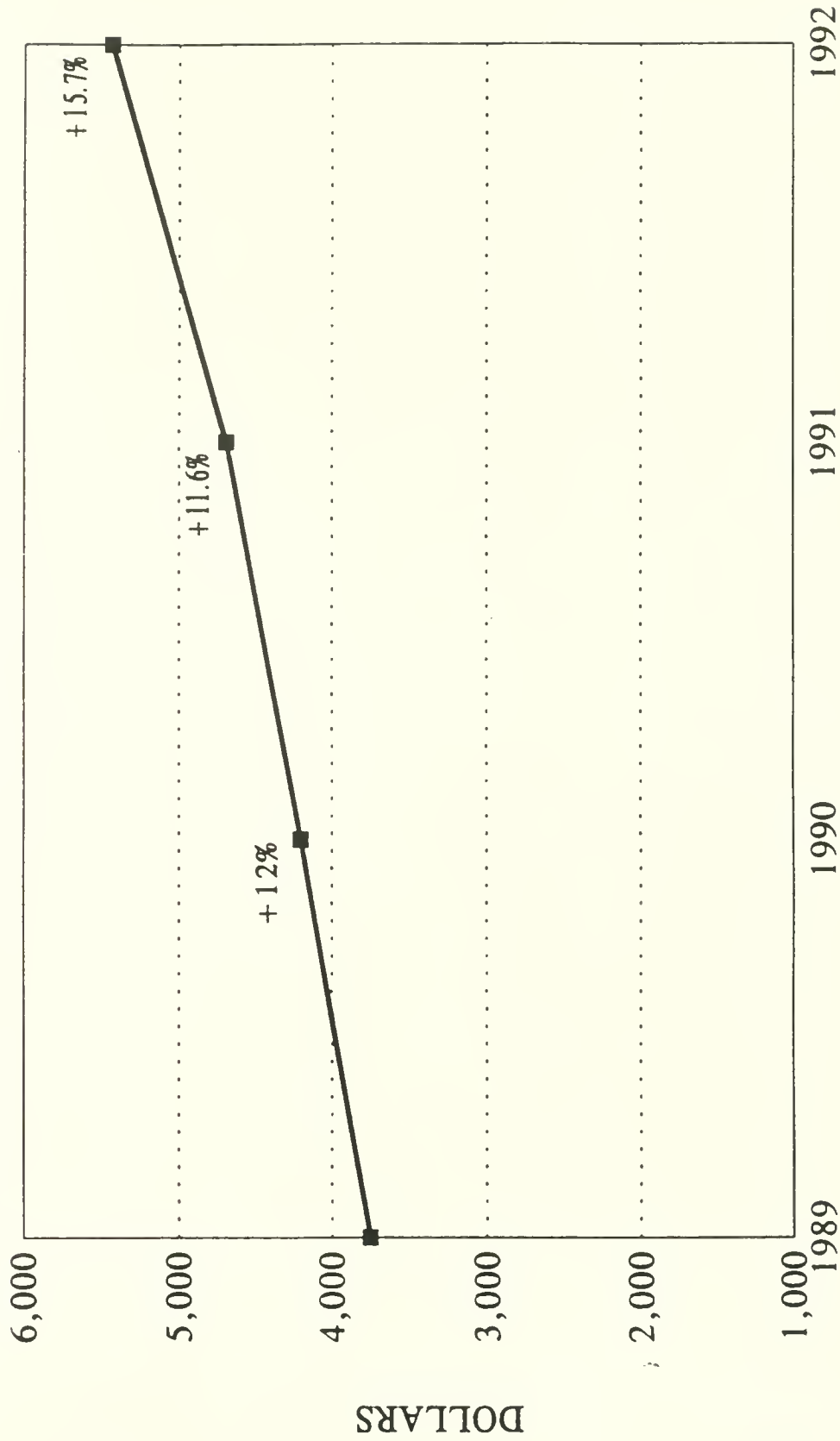
CHANGE IN MONTHLY FAMILY PREMIUMS FOR A POPULAR BC/BS INSURANCE PRODUCT



SOURCE: Blue Cross/Blue Shield of Montana

Health Systems Research, Inc.

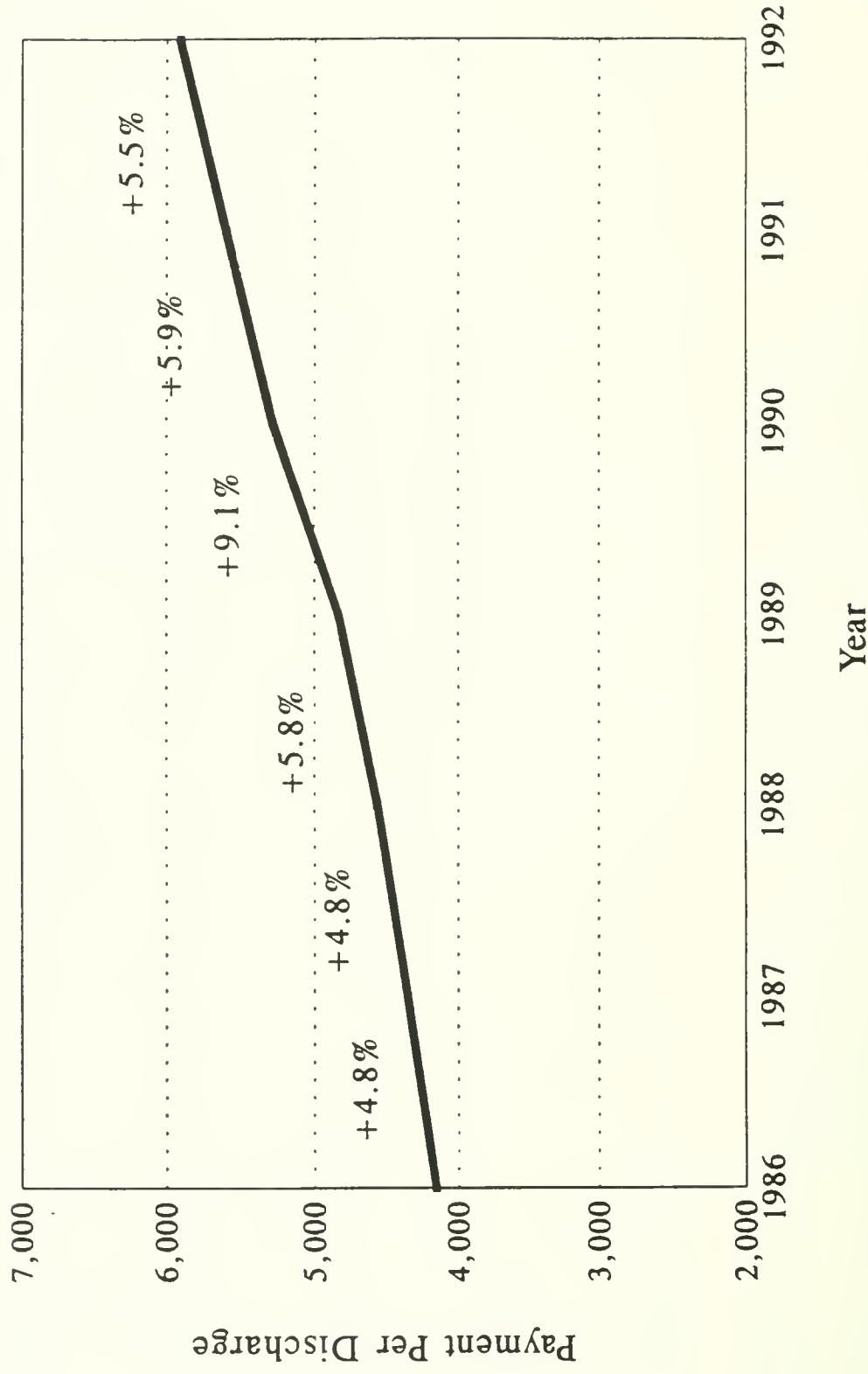
GROWTH IN HOSPITAL INPATIENT CHARGES PER CASE FOR BLUE CROSS/BLUE SHIELD



Source: Blue Cross/Blue Shield of Montana, Annual Report 1991, 1992

MEDICARE PAYMENT PER DISCHARGE

National Trend



Medicare Cost Per Discharge

Montana

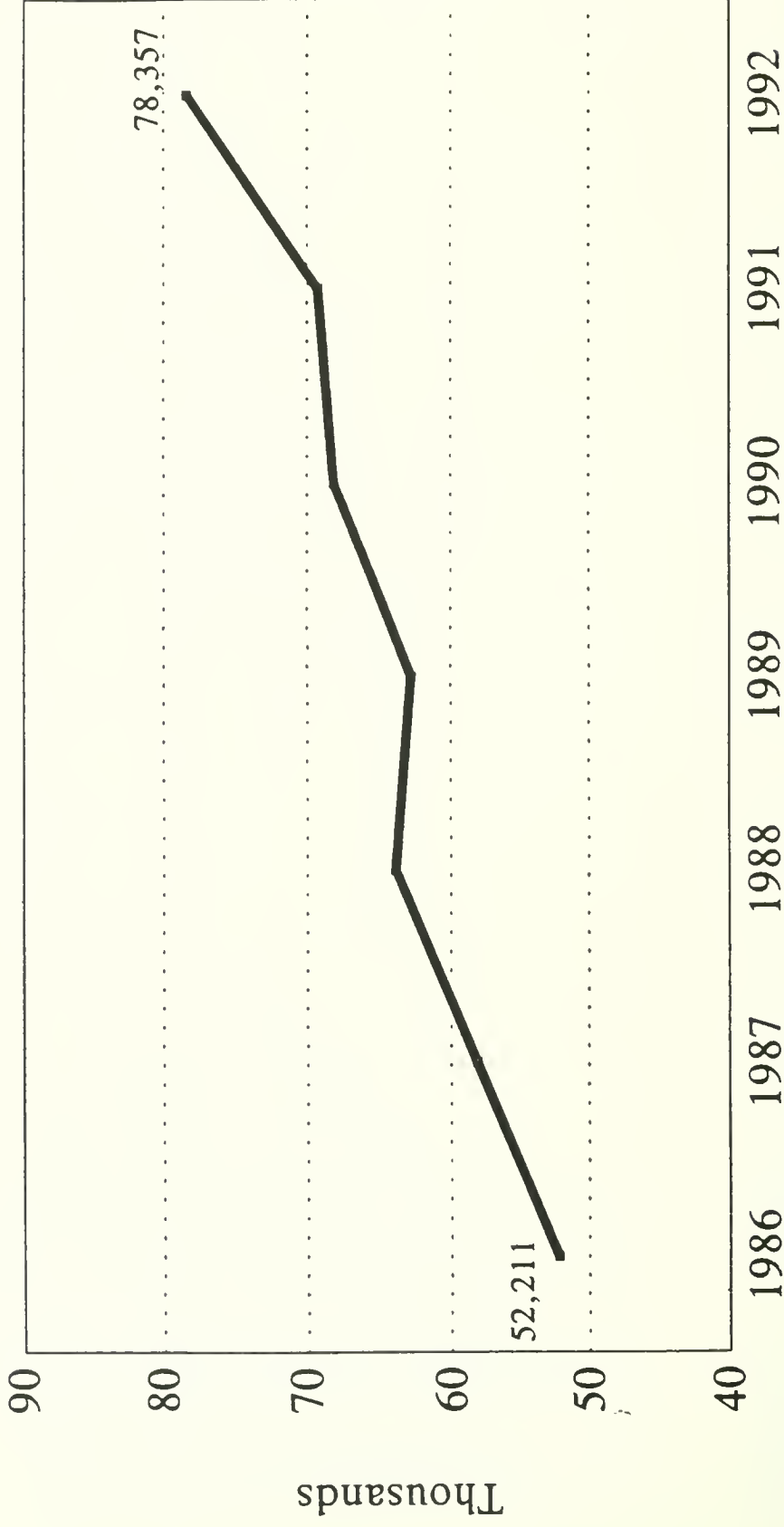
	YR 1990	YR 1991	YR 1992
Total Discharges	39,820	40,850	39,305
Total Inpatient Days	261,395	275,345	248,500
Average Length of Stay	6.6	6.7	6.3
Inpatient Payments (Millions)	\$164.70	\$183.19	\$190.34
Payment Per Discharge	\$4,136	\$4,484	\$4,842
Increase in Payment Per Discharge	NA	+8.4%	+7.9%

SOURCE: HCFA, Office of Direct Reimbursement

Health Systems Research, Inc.

MEDICAID GROWTH OVER TIME

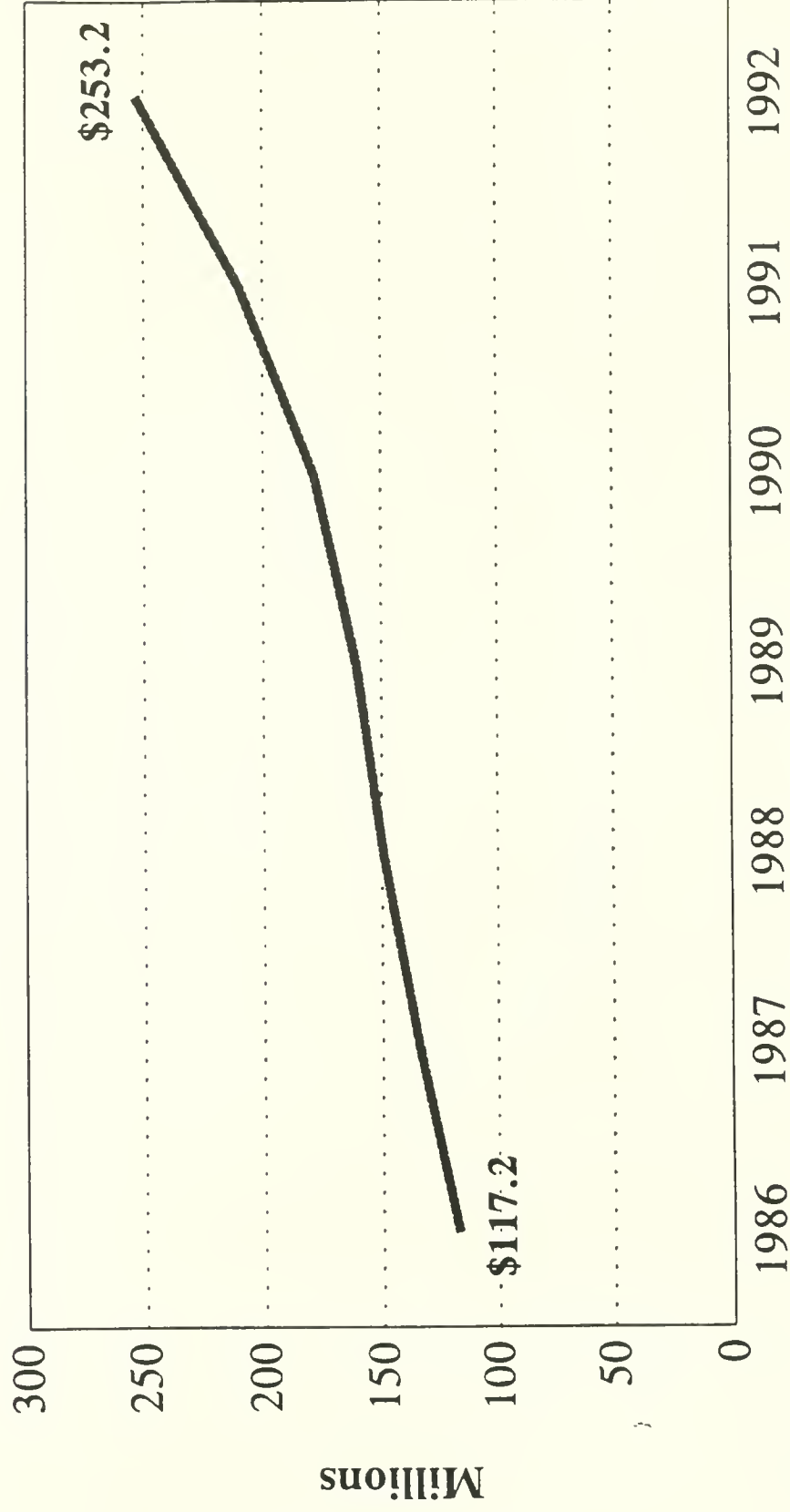
Number of Recipients



SOURCE: Montana Department of Social and Rehabilitative Services' Medicaid Report; Montana 2082 Data

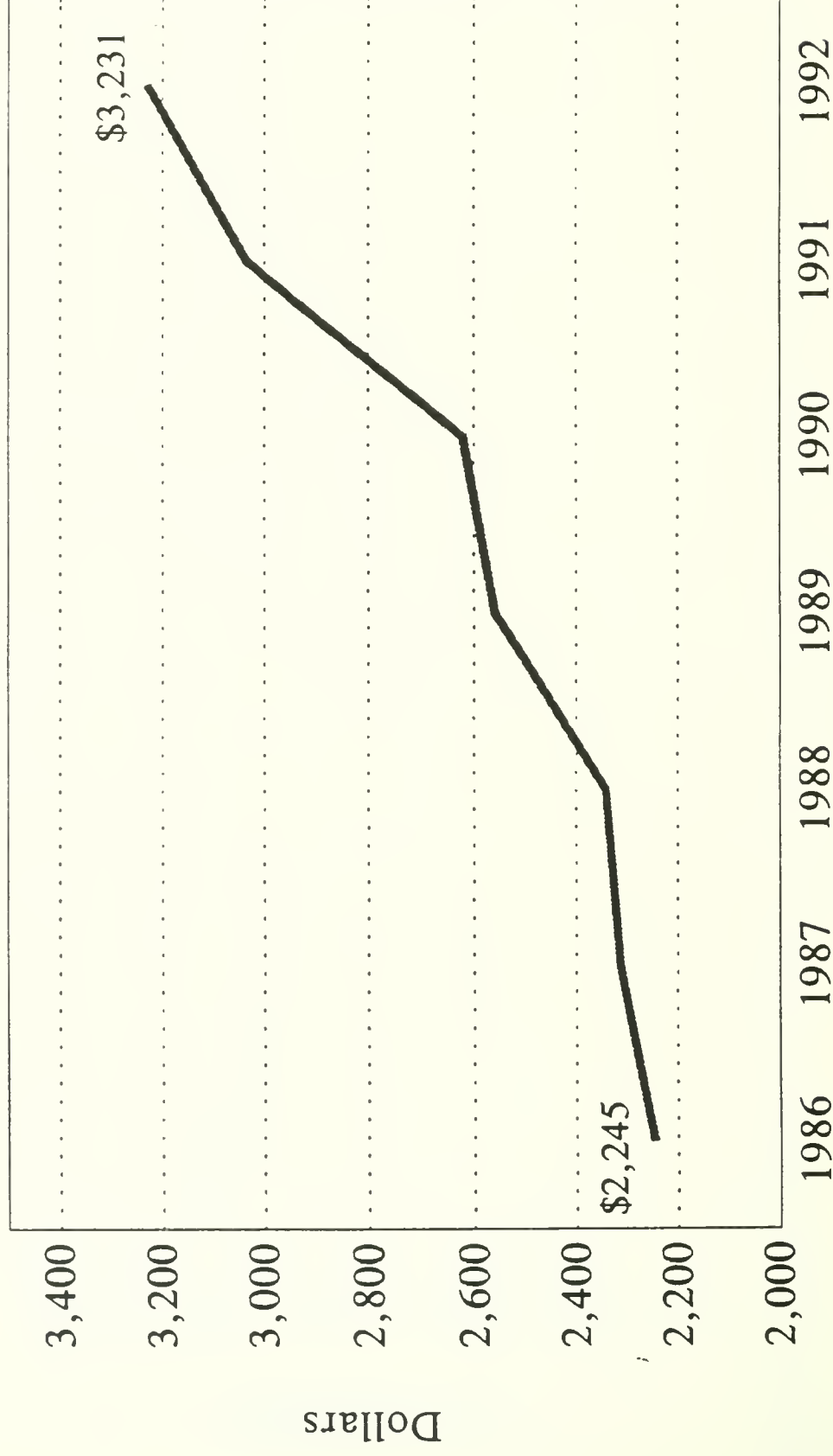
MEDICAID GROWTH OVER TIME

Total Expenditures



MEDICAID GROWTH OVER TIME

Cost Per Recipient



SOURCE: Department of Social and Rehabilitative Services' Medicaid Report; Montana 2082 Data.

MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY

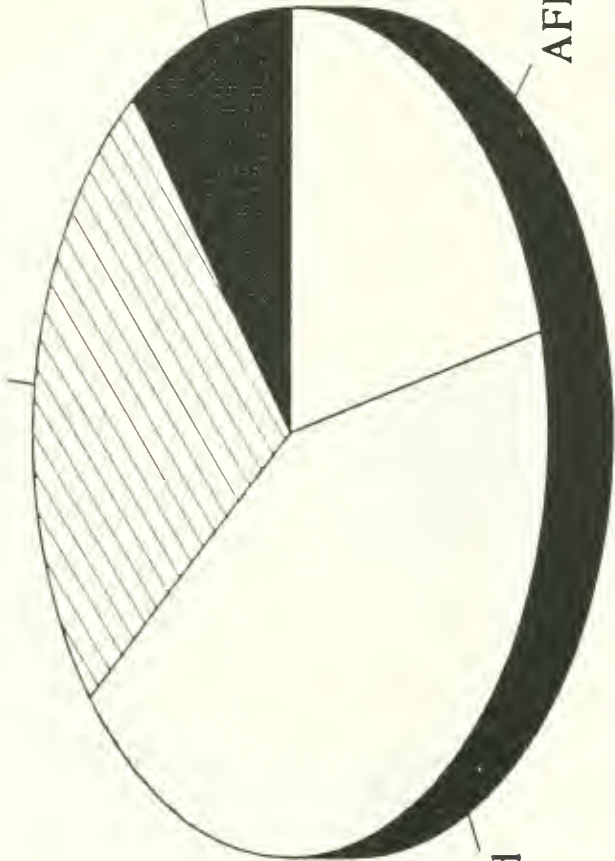
FY 1992

Blind, Disabled & Title XIX
25%

Over 65
11%

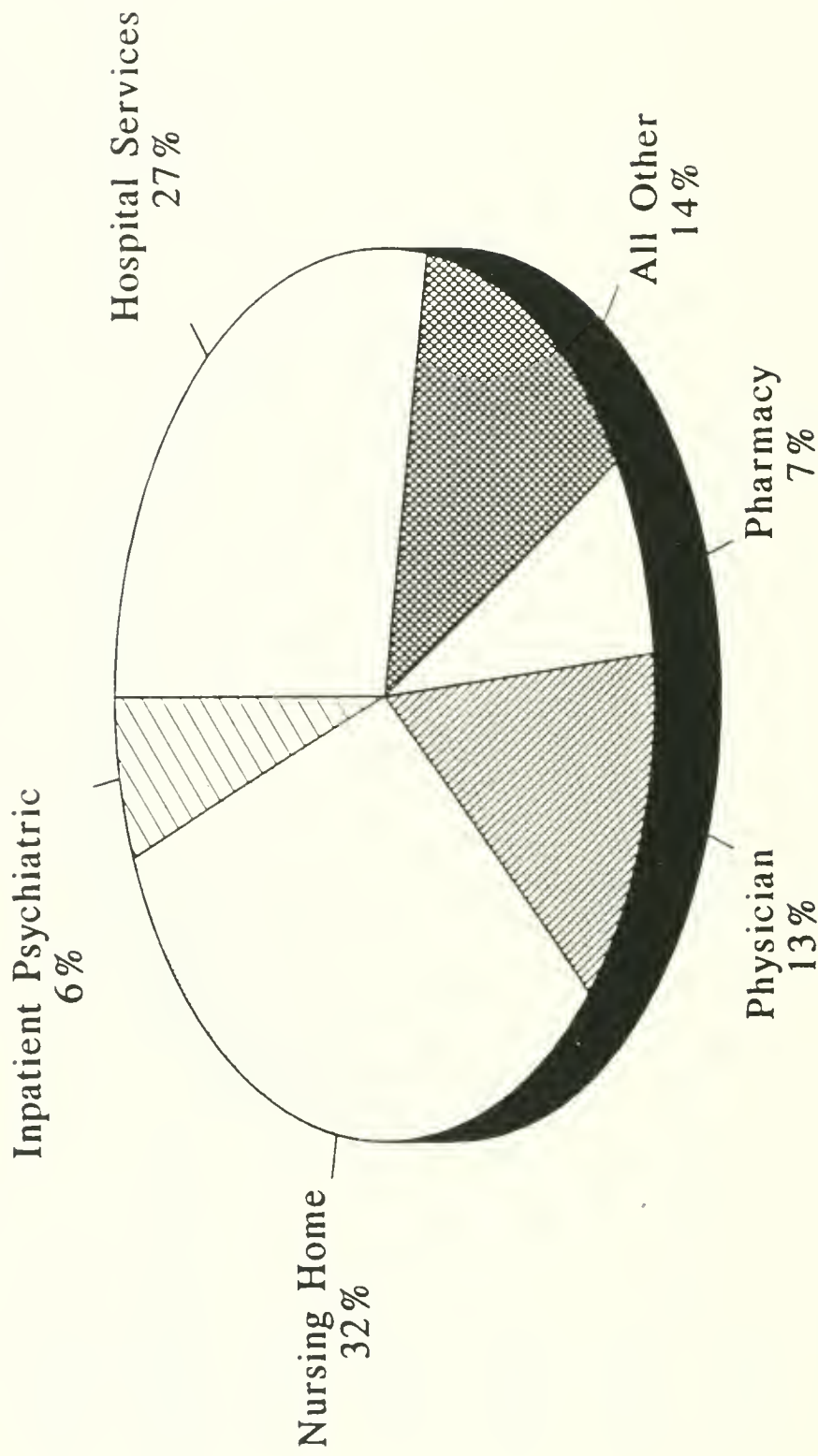
AFDC & Medicaid Adult
21%

AFDC & Medicaid Child
43%



Total Recipients: 78,357

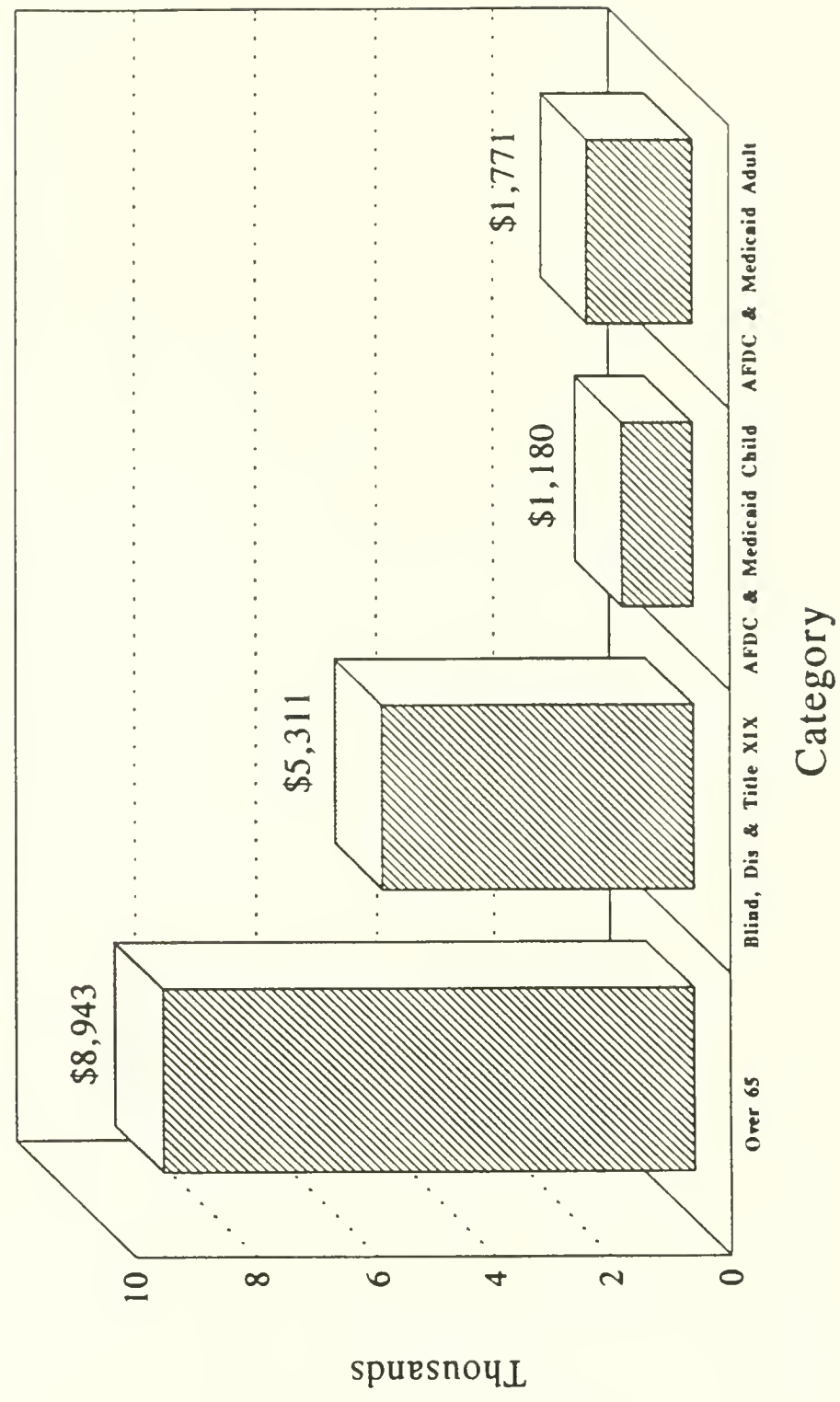
MEDICAID PAYMENTS FOR SELECTED SERVICES



Total Medicaid Expenditures: \$248.2 million

MEDICAID EXPENDITURES PER RECIPIENT

By Eligibility Category



SOURCE: Montana 2082 Data

HOSPITAL UTILIZATION PATTERNS

YEAR	AVERAGE LENGTH OF STAY	HOSPITAL ADMISSIONS	INPATIENT DAYS
1985	5.0	110,507	555,844
1986	5.1	108,758	553,971
1987	5.2	103,380	541,574
1988	5.1	105,052	540,374
1989	5.6	101,710	567,852
1990	5.6	101,933	570,117
1991	5.6	98,200	554,335
1992	5.4	99,194	536,404

SOURCE: Montana Hospital Association Survey Data

Health Systems Research, Inc.

REVENUES AND EXPENSES – 1992

Montana Hospitals, By Bed Size

<u>REVENUE</u>	<u>All Hospitals</u>	<u>Hospitals with less than 30 Beds</u>	<u>Hospitals with 30–89 Beds</u>	<u>Hospitals with 90–189 Beds</u>	<u>Hospitals with 190 and More Beds</u>
Inpatient Revenue	641,982,478	26,695,345	72,526,012	163,930,996	380,543,729
Outpatient Revenue	244,740,642	25,923,087	47,569,799	70,447,063	103,167,091
Total Gross Patient Revenue	886,723,120	52,618,432	120,095,811	234,378,059	483,710,820
Deductions from Revenue	220,146,869	7,130,353	23,245,273	56,971,694	133,501,131
Total Net Patient Revenue	666,576,251	45,488,079	96,850,538	177,406,365	350,209,689
Other Operating Revenue	33,730,575	3,224,896	4,500,883	8,123,233	17,954,132
Total Revenue	700,306,826	48,712,975	101,351,421	185,529,598	368,163,821
Percent of Total Revenues	100.00%	6.96%	14.47%	26.49%	52.57%
<u>EXPENSES</u>					
Payroll Expense	277,168,283	23,442,381	38,613,542	76,291,696	140,438,943
Employee Benefits	52,329,691	4,519,577	7,124,001	15,959,572	25,034,452
Professional Fees	26,713,067	2,644,127	5,083,669	11,072,947	8,009,395
Depreciation Expense	45,908,097	2,893,044	6,635,586	12,515,927	24,009,282
Interest Expense	18,362,494	919,129	2,883,731	4,195,093	10,488,065
Bad Debt Expense	23,140,481	1,766,871	5,012,903	4,287,180	12,073,527
All Other Expenses	217,799,519	15,754,243	27,826,050	50,103,370	125,058,035
Total Nonpayroll Expenses	384,253,349	28,496,991	54,565,940	98,134,089	204,672,756
Total Expenses	661,421,632	51,939,372	93,179,482	174,425,785	345,111,699
Gain (Loss) from Operations	38,885,194	(3,226,397)	8,171,939	11,103,813	23,052,122
Gain (Loss) as a % of Total Expenses	5.88%	-6.21%	8.77%	6.37%	6.68%
Nonoperating Gains	15,375,417	2,982,697	3,127,687	4,847,274	4,456,312
Nonoperating Losses	1,360,128	304,918	625,062	46,617	383,531
Revenue Less Expense	52,900,483	(548,618)	10,674,564	15,904,470	27,124,903
Charge–Cost Ratio (Ratio of Gross Patient Revenues to Total Expenses)	1.34	1.01	1.29	1.34	1.40

SOURCE: Montana Hospital Association

DEDUCTIONS FROM REVENUE— 1992

Montana Hospitals, By Bed Size

<u>DEDUCTIONS</u>	<u>All Hospitals</u>	<u>Hospitals with Less than 30 Beds</u>	<u>Hospitals with 30-89 Beds</u>	<u>Hospitals with 90-189 Beds</u>	<u>Hospitals with 190 and More Beds</u>
Medicare Discounts	\$157,294,146	\$4,182,974	\$18,476,564	\$37,796,036	\$97,243,416
Medicaid Discounts	\$32,779,710	\$1,566,176	\$2,411,772	\$9,828,124	\$19,100,209
Other Government Contractual Adj	\$10,148,699	\$261,048	\$559,172	\$2,286,240	\$7,042,239
Third Party Payor Contractual Adj	\$5,802,398	\$286,607	\$425,464	\$1,459,527	\$3,630,800
All Other Discounts	\$4,331,198	\$421,322	\$623,663	\$1,236,512	\$2,209,404
Charity	\$9,790,718	\$412,226	\$748,638	\$4,365,255	\$4,275,063
Total Revenue Deductions	\$220,146,869	\$7,130,353	\$23,245,273	\$56,971,694	\$133,501,131

;

FINANCIAL INDICATORS – 1992

Montana Hospitals, By Bed Size

<u>FINANCIAL INDICATORS</u>	<u>All Hospitals</u>	<u>Hospitals with Less than 30 Beds</u>	<u>Hospitals with 30-89 Beds</u>	<u>Hospitals with 90-189 Beds</u>	<u>Hospitals with 190 and More Beds</u>
Cost Per Case	\$4,827.57	\$2,661.70	\$2,981.73	\$4,438.73	\$6,221.05
Outpatient Percent of Total Gross Patient Revenue	27.6%	49.3%	39.6%	30.1%	21.3%
Medicare Charges Percent of Total Gross Patient Revenue	44.2%	40.2%	31.9%	41.8%	48.9%
Medicaid Charges Percent of Total Gross Revenue	8.6%	11.1%	6.0%	11.2%	7.7%
Employee Expense Percent of Total Expense	49.8%	53.8%	49.1%	52.9%	47.9%
Capital Expense Percent of Total Expense	9.7%	7.3%	10.2%	9.6%	10.0%

UTILIZATION INDICATORS – 1992

Montana Hospitals, By Bed Size

<u>UTILIZATION INDICATORS</u>	<u>All Hospitals</u>	<u>Hospitals with Less than 30 Beds</u>	<u>Hospitals with 30-89 Beds</u>	<u>Hospitals with 90-189 Beds</u>	<u>Hospitals with 190 and More Beds</u>
Admissions – Total	99,194	9,900	18,872	27,485	43,643
Admissions – Hospital	97,915	9,265	18,268	27,438	43,643
Admissions – Swing Bed	1,279	635	604	47	0
Inpatient Days – Total	536,404	60,651	83,410	121,567	272,967
Inpatient Days – Hospital	511,480	44,625	74,710	121,283	272,967
Inpatient Days – Swing Bed	24,924	16,026	8,700	284	0
Average Length of Stay – Total	5.41	6.13	4.42	4.42	6.25
Average Length of Stay – Hospital	5.22	4.82	4.09	4.42	6.25
Average Length of Stay – Swing Bed	19.49	25.24	14.4	6.04	
Average Percent of Occupancy – Total	48.7%	35.0%	36.5%	47.6%	59.5%
Average Percent of Occupancy – Hospital	46.4%	25.7%	32.7%	47.5%	59.5%
Average Percent of Occupancy – Swing Bed	2.3%	9.2%	3.8%	0.1%	0.0%

OTHER INDICATORS— 1992

Montana Hospitals, By Bed Size

OTHER INDICATORS	All Hospitals	Hospitals with Less than 30 Beds	Hospitals with 30-89 Beds	Hospitals with 90-189 Beds	Hospitals with 190 and More Beds
Licensed Beds	3,017	475	626	699	1,257
Inpatient Revenue Percent of Total					
Gross Patient Revenue	72.4%	50.7%	60.4%	69.9%	78.7%
Net Patient Revenue Percent of Total					
Gross Patient Revenue	75.2%	86.4%	80.6%	75.7%	72.4%
Total Revenue Deductions/ Admissions (Adjusted)	\$1,606.80	\$365.40	\$743.85	\$1,449.80	\$2,406.52
Bid Debts Expense Percent of Total					
Gross Patient Revenue	2.6%	3.4%	4.2%	1.8%	2.5%
Bid Debts/Admissions (Adjusted)	\$74.07	\$13.38	\$17.89	\$58.18	\$126.94
Payroll Expenses Percent of Total Expenses	41.9%	45.1%	41.4%	43.7%	40.7%
Employee Benefits Percent of Total Expenses	7.9%	8.7%	7.6%	9.1%	7.3%
Net Patient Revenue Percent of Total Expenses	100.8%	87.6%	103.9%	101.7%	101.5%
Depreciation Expense Percent of Total Expenses	6.9%	5.6%	7.1%	7.2%	7.0%
Interest Expense Percent of Total Expenses	2.8%	1.8%	3.1%	2.4%	3.0%
Labor Expense Per FTE	\$396,165	\$45,266	\$229,837	\$6,150,085	
FTEs per Adjusted Occupied Bed	0.41	1.89	0.53	0.03	0.00
Capital Cost per Adjusted Discharge	\$480.16	\$227.75	\$315.66	\$426.22	\$624.22
Total Net Margin	0.056	-0.066	0.081	0.060	0.063
Net Patient Margin	0.008	-0.142	0.038	0.017	0.015
Medicare Average Length of Stay	6.46	4.62	5.00	6.24	7.54
Non-Medicare Average Length of Stay	4.90	9.69	4.27	3.46	5.35
Medicare Patient Days Percent of Total					
Patient Days	47.7%	32.5%	46.1%	49.3%	51.0%
Medicare Discharges Percent of Total					
Discharges	40.9%	50.2%	42.2%	35.0%	42.4%
Discharges per Bed	32.12	17.88	29.09	39.23	34.59
Current Ratio	2.37	1.8	3.25	1.93	2.53
Average Payment Period	60.86	93.07	52.91	63.29	56.74
Long Term Debt to Fixed Asset Ratio	0.662	0.362	0.567	0.648	0.754
Long Term Debt to Equity Ratio	0.586	0.351	0.464	0.530	0.700
Mark-up	1.392	1.075	1.337	1.390	1.454
Return on Assets	0.060	-0.008	0.078	0.076	0.058
Assets per Bed	292,347	150,734	218,156	298,516	372,098
Equity Financing	0.554	0.596	0.62	0.565	0.521
Non-Operating Revenue Ratio	3.16	-5.993	0.352	0.308	0.178

SOURCE: Montana Hospital Association

5. MONTANA HEALTH CARE RESOURCES

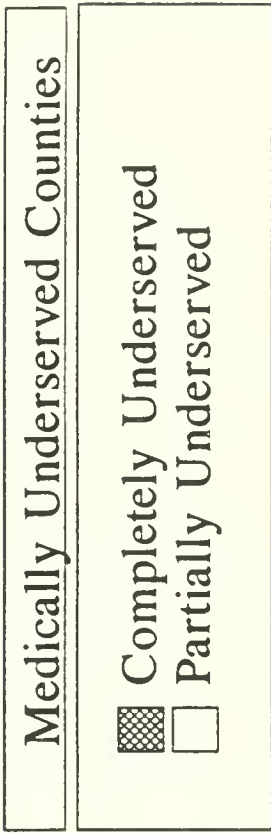
ESTIMATED PHYSICIANS IN MONTANA

COUNTY	# ACTIVE PHYSICIANS	PRIMARY CARE PHYSICIANS	"MUA" STATUS
TOTAL	1,244	591	
Beaverhead	10	7	PARTIAL
Big Horn	12	12	✓
Blaine	2	2	✓
Broadwater	3	2	
Carbon	7	5	
Carter	0	0	
Cascade	170	62	PARTIAL
Chouteau	3	3	✓
Custer	21	12	
Daniels	2	2	
Dawson	8	6	
Deer Lodge	14	9	
Fallon	2	2	
Fergus	15	10	
Flathead	116	49	
Gallatin	88	44	
Garfield	0	0	
Glacier	11	10	✓
Golden Valley	0	0	✓
Granite	1	1	✓
Hill	22	9	
Jefferson	7	4	
Judith Basin	0	0	✓

COUNTY	# ACTIVE PHYSICIANS	PRIMARY CARE PHYSICIANS	"MUA" STATUS
Lake	22	19	PARTIAL
Lewis & Clark	103	48	
Liberty	2	2	
Lincoln	16	10	
Madison	6	5	PARTIAL
McCone	1	1	
Meagher	1	1	√
Mineral	3	2	√
Missoula	207	69	PARTIAL
Musselshell	2	2	√
Park	15	13	
Petroleum	0	0	√
Phillips	2	1	PARTIAL
Pondera	6	4	PARTIAL
Powder River	0	0	√
Powell	4	3	
Prairie	0	0	√
Ravalli	23	12	PARTIAL
Richland	12	6	
Roosevelt	11	10	√
Rosebud	6	5	
Sanders	4	3	
Sheridan	3	3	
Silver Bow	66	27	
Stillwater	5	4	
Sweet Grass	1	1	PARTIAL
Teton	2	2	

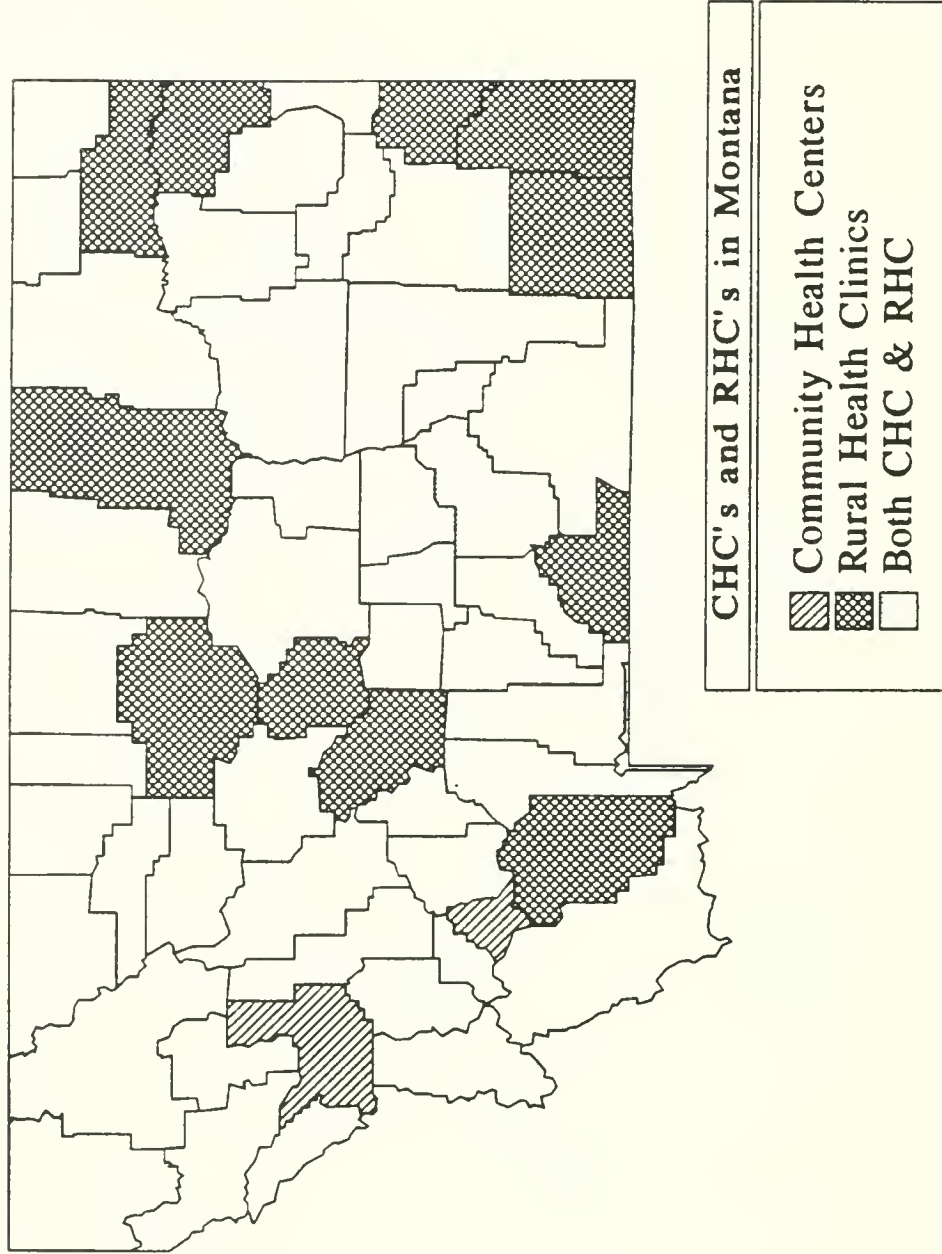
COUNTY	# ACTIVE PHYSICIANS	PRIMARY CARE PHYSICIANS	"MUA" STATUS
Toole	2	2	
Treasure ..	0	0	✓
Valley	7	3	✓
Wheatland	1	1	
Wibaux	0	0	PARTIAL
Yellowstone	283	81	PARTIAL

Source: Montana Department of Health and Environmental Sciences' "County-Based Health Planning" Book



Health Systems Research, Inc.

LOCATION OF CHC's AND RHC's IN MONTANA



SOURCE: Montana Community Based Health Planning

Health Systems Research, Inc.

ESTIMATED NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

	Nurse Practitioners		Physician Assistants	
TOTAL	97	100.0%	37	100.0%
In Metro	17	18%	5	14%
In Rural	47	49%	11	30%
In Frontier	33	34%	21	57%

SOURCE: Montana Department of Health and Environmental Sciences' "County-Based Health Planning" Book ;
Montana 2082 Data.

NURSING HOME FACILITIES

	SKILLED NURSING FACILITIES (SNF)	INTERMEDIATE CARE FACILITIES (ICF)
Number of Facilities	93	45
Number of Beds	4910	2245
Beds Per Facility	52.8	49.9

Montana Indian Health Services

Service Unit	No. Positions/Specialty
Blackfeet Hospital	3 - OB/GYN (1 - vacant) 1 - Radiology (vacant) 7 - Family Practice (1-CC) 1 - Internal Medicine 2 - Pediatricians (1-CC)
Crow Hospital	2 - OB/GYN 7 - Family Practice 1 - Internal Medicine 1 - Pediatrician
Lodge Grass Health Center	2 - Family Practice
Fort Belknap Hospital	3 - Family Practice (1-CC) 2 - General Practice (1-CC)
Fort Peck - Poplar Health Center	4 - Family Practice 1 - Emergency Medicine
Wolf Point Health Center	2 - Family Practice 1 - Internal Medicine
Northern Cheyenne Health Center	2 - Family Practice (1-CC) 2 - General Practice 1 - Internal Medicine 1 - Pediatrician
Rocky Boy Health Center	1 - Family Practice 1 - General Practice 1 - Pediatrician
Flathead Health Center	1 - Internal Medicine (1-CC)
Area Office (provides physician coverage for other IHS facilities)	1 - Internal Medicine/EPI 1 - Family Practice (1-CC) 1 - General Practice (1-CC) 1 - General Medical Officer

Source: Indian Health Service, March 1994

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6. MONTANA REVENUE SOURCES

MAJOR STATE REVENUE SOURCES

FY 1992

SOURCE OF REVENUE	AMOUNT OF RESOURCE (Millions)	PERCENT OF STATE REVENUE
Income	\$ 321.6	60.2%
Corporation License	\$ 57.7	10.8%
Coal Severance	\$ 54.1	10.1%
Oil Severance	\$ 20.4	3.8%
Workers' Comp. Payroll	\$ 14.1	2.6%
Inheritance	\$ 11.3	2.1%
All Other	\$ 54.8	10.3%
TOTAL REVENUES	\$ 534.0	100.0%

SOURCE: Montana Department of Revenue Biennial Report (1990 - 1992)

Health Systems Research, Inc.

MAJOR STATE REVENUE SOURCES

FY 1984

SOURCE OF REVENUE	AMOUNT OF RESOURCE (Millions)	PERCENT OF STATE REVENUE
Income	\$ 170.4	37.3%
Coal Severance	\$ 82.8	18.1%
Gas License	\$ 61.1	13.4%
Oil Severance	\$ 49.0	10.7%
Corporation	\$ 35.4	7.8%
Diesel Fuel	\$ 17.8	3.9%
All Other	\$ 40.2	8.8%
TOTAL REVENUES	\$ 456.7	100.0%

SOURCE: Montana Department of Revenue Biennial Report (1986 - 1988)

II. INTEGRATION OF INDIAN HEALTH SERVICE AND VETERANS AFFAIRS BENEFITS

THE POTENTIAL FOR INTEGRATION OF INDIAN HEALTH SERVICE AND VETERANS AFFAIRS PROGRAM BENEFITS IN MONTANA'S HEALTH CARE REFORM PROCESS

Introduction

Senate Bill 285 requires that the Montana Health Care Authority explore the "integration, to the extent possible under federal and state law, of benefits provided under the health care system with benefits provided by the Indian health service and the United States department of veteran affairs and benefits provided by the medicare and medicaid programs". The purpose of this report is to relate the Authority's continuing efforts at, first, responding to the statutory language regarding integration of benefits of the Indian Health Service and Veterans Affairs, and, second, responding to the various groups and individuals who would be affected by the integration suggested in the statute. (A discussion of the potential for integrating Medicare and Medicaid benefits is contained in Volume I of the overall report.) The Indian Health Service (IHS) and Veterans Affairs (VA) health delivery systems receive all or most of their funding directly from the federal government and provide services to specific target populations. The components of these service delivery systems (hospitals, clinics, physicians, etc.) have been included in the relevant presentation of resources in the "Statewide Health Care Resource Management Plan," found in Volume III of the overall report.

The integration of federally funded delivery systems into a reformed health care system in Montana would require specific federal action and, in the case of IHS, negotiations with individual sovereign tribes. Therefore, the ultimate structure and extent of the possible integration of these delivery systems is still unclear. However, continuing communications between the Authority and tribal representatives, IHS officials, VA officials, military personnel, veterans, and Indian people have resulted in a better understanding by the Authority of issues which are central to each of these areas. Irrespective of the outcome of the deliberations on comprehensive health care reform during the 1995 Montana legislative session, these discussions should continue in efforts to make appropriate and affordable health care available to all Montanans.

In order to truly understand the potential for integrating IHS and VA benefits into Montana's health care system, it is first necessary to understand the two delivery systems in terms of who they serve, the facilities they operate, and their ability to coordinate with state-level reform. For the IHS and the VA health care delivery systems, then, the following areas are discussed: information on the populations served, including any information on limits or restrictions to services which are placed upon the target populations; facilities and services provided by the system and the funding of those services; and, the possibilities and possible limitations of the coordination of the federally funded health systems relative to state health care reform.

Indian Health Service

The mission of the IHS is to provide a comprehensive health services delivery system for Indian people and Alaskan Natives with the goal of improving the health status of these populations. To achieve this goal, the IHS has developed a health care system that provides both clinical and public health services. The total nationwide IHS budget for federal fiscal year (FFY) 1992 was \$1.5 billion. It is important to note that more than one federal waiver may be necessary if the IHS and Montana's tribes and urban clinics agreed to pool funding mechanisms with a new health care delivery system. Different appropriations are made to the IHS based on whether the covered services are provided on or off reservation and whether they are secured through contract with non-IHS health care providers.

Montana's Indian Population. According to the Billings Area Indian Health Service Office, there were 55,625 enrolled members of tribes living in Montana as of March 1993. Bureau of Indian Affairs figures indicate that the total number of enrolled tribal members has increased to a current count of 56,600, with about 60 percent (34,000) estimated as residing within the borders of Montana's seven reservations. However, tribal membership is but one estimate of the size of the Indian population in Montana. Enrollment rules vary from tribe to tribe, and the number of people who consider themselves Indian is likely to be somewhat higher. In addition, as will be discussed below, tribal membership is neither a condition nor a guarantee of eligibility to receive services through the IHS.

The Indian people of Montana are generally poorer and in poorer health than the rest of the state's population. According to 1990 census data, nearly half of the Indian people living on Montana's reservations have incomes below the federal poverty level, compared to 12 percent for the state as a whole. In Montana, the infant mortality rate for Indian people is 16.1 per 1,000 births (1986–1990 rate, IHS Billings Area Profile, 1993). This is considerably higher than the overall state rate of 9.2 per 1,000 births (1987–1991 rate, Montana Vital Statistics, 1990–1991). Other indicators of poor health among Montana's Indian people are the higher rates of both cirrhosis of the liver and mortality due to auto accidents (IHS Billings Area Profile, 1993).

Indian People's Access to IHS Services in Montana. For Montana's Indian population, access to IHS facilities requires that Indian people be considered in two categories: those who live within the borders of an IHS service unit; and those who live outside the borders of an IHS service unit.

- ***Residents of IHS service units.*** Residents of an IHS service unit who are tribal members, descendants of an enrolled tribal member, or are considered a tribal member by the tribal community at large, may receive all available services from the IHS. IHS services include both those which can be provided by IHS hospitals, health centers and health stations, as well as services provided by private, non-IHS providers which the IHS reimburses on a contractual basis. The services which the IHS purchases from non-IHS providers, known as contract health services, represent much of the tertiary and specialty care used by those eligible for IHS services. The availability of both direct services from IHS facilities and contract services provides service area residents with relatively comprehensive health service coverage.
- ***Non-residents of IHS service units.*** Indian people who are not residents of a service unit can receive services at urban Indian programs or travel to an IHS facility to be served. Indian people who live outside an IHS service area, however, are limited in their access to IHS services in two ways. First, the distance they may need to travel to an IHS facility to receive care may be significant. Second, and more important, individuals who have not resided within the boundaries of an IHS service unit for over 180 days are ineligible to receive contract health services. Due to these limitations, Indian people who live outside a service unit can, at best, access primary care and limited hospitalization through the IHS.

The IHS system does not fulfill all the health care needs of Montana's Indian population. Indian people seek care outside of the IHS system for a number of reasons, such as barriers to access as a result of distance, IHS eligibility criteria or treatment limitations of the IHS system. Nationally, less than half of Indian people eligible to receive IHS services use IHS services exclusively. Most use a combination of IHS and non-IHS services, depending upon the IHS's capacity to provide needed care, the accessibility of that care in their particular area, and their individual resources. Indian people with higher incomes and other sources of insurance coverage are even less likely to

make exclusive use of IHS facilities and services (Cunningham, 1993).

The Indian Health Service. The IHS is comprised of 12 regional administrative offices, which are divided into smaller service units. The service units are directly responsible for the management of service delivery. The boundaries of a service unit encompasses the area containing the reservation it serves as well as the counties that are contiguous to the reservation. Montana is served by the Billings Regional Area Office, which consists of seven service units corresponding to the seven reservations in the state.

IHS Expenditures in Montana. In FFY 1992, the total IHS budget for Montana was \$87.2 million. The IHS reported an active user population of over 49,000 (the IHS considers an active user to be anyone who has used any IHS direct service within the last three years). The major components of Montana's IHS budget were: IHS clinical facilities; contract health services; public health services; facilities and administration; and urban Indian clinics. Each budget category is discussed briefly below.

- **Clinical facilities.** In FFY 1992, the IHS in Montana operated three hospitals, five health centers and four health stations. IHS hospitals in Montana are small rural facilities (all have less than 35 beds) that provide both outpatient and inpatient services. Health centers are freestanding outpatient facilities that are open at least 40 hours per week and are staffed by a full-time physician. Health stations are outpatient facilities that operate less than 40 hours per week and may be staffed only by mid-level providers. In FFY 1992, IHS facilities in Montana received over 283,000 outpatient visits and over 3,100 inpatient admissions. The IHS budget for the operation of clinical facilities was \$50.5 million in FFY 1992.
- **Contract health services.** The IHS facilities are not able to provide all care that patients may need. As noted earlier, specialty, tertiary and even primary care services that exceed the capacity of the IHS system are purchased from private providers on a contract basis. Contract services are purchased only for individuals with no other payment source such as Medicare or Medicaid. Contract services, like all IHS services, are limited to a yearly budgeted amount. To assure that the limited funds for contract services are allocated to persons with the greatest needs, the IHS uses a rationing system based upon medical priorities. In FFY 1992, \$24.5 million went to the provision of contract services.
- **Public health.** The provision of public health services is an important aspect of the IHS's mission to provide a health care system for all Indian people. Public health functions include public health nursing, health education, and environmental health, such as sanitation and water systems. In FFY 1992, the IHS budget for public health activities in Montana was \$5.7 million.
- **Facilities and administration.** General administrative functions as well as the maintenance, expansion and construction of all IHS facilities in Montana are managed centrally by the IHS regional office in Billings. In FFY 1992, the total IHS administration and facility budget for Montana was \$3.3 million.
- **Urban Indian clinics.** There are five urban Indian clinics in Montana. Three clinics provide direct clinical services and two clinics provide only community outreach, referral to other services, and substance abuse treatment. Urban Indian clinics are Indian-run, non-profit facilities. They are not operated by the IHS, but they do receive IHS funds. Urban clinics do not have tribal affiliations, but the governing boards usually include tribal representatives. In FFY 1992, Montana's

urban Indian programs responded to 9,930 medical visits and 39,744 total visits by Indian people. In FFY 1992, the IHS funding commitment to Montana's urban Indian clinics was \$0.76 million.

Since FFY 1992, a significant change has occurred in the organization of IHS services in Montana. In 1993, the Confederation of the Salish and Kootenai Tribes, which reside within the IHS's Flathead Service Unit, decided to assume the responsibility for the operation of their health services programs. (Under the provisions of the Indian Self-Determination and Education Assistance Act of 1975, a tribe may assume control over the operation of local IHS facilities.) Although the tribe continues to receive funding from the IHS, the local facilities are now operated and managed by the governing tribes.

IHS Funding in Montana. The majority of the \$87.2 million IHS budget for Montana in FFY 1992 was funded by a direct federal appropriation. In addition to the \$78.7 million in direct federal support, the IHS in Montana also received Medicaid reimbursements of \$5.8 million, Medicare reimbursements of \$1.8 million and other third-party reimbursements of \$0.9 million. While third-party reimbursements represent less than 10 percent of all IHS funding in Montana, they make up nearly 17 percent of the budget for direct clinical services and, therefore, are vital to the operation of local IHS facilities.

Medicaid represents the most significant source of third-party reimbursements to IHS facilities. Services provided by IHS facilities to Medicaid-eligible Indian people receive a 100 percent federal Medicaid match compared to the 71 percent federal match that the state receives for the services delivered to other Medicaid eligible individuals. In an effort to generate revenue to support its facilities and services, the IHS facilities in Montana have increased their efforts to obtain Medicaid reimbursement. Medicaid payments to the IHS increased from \$3.4 million in FFY 1991 to \$5.8 million in FFY 1992, and to \$7.3 million in FFY 1993. The 100 percent match only applies to services provided by the IHS. Services received by Medicaid-eligible Indian people from non-IHS facilities are reimbursed at the regular federal matching rate.

IHS Coordination with State Health Reform Proposals. Speaking on behalf of the Fort Peck Tribes before the Regional Forum on Indian Health Reform in Billings, Montana on April 7-8, 1994, Caleb Shields, Tribal Chairman, stated that "Health Care reform could provide a potential for life-saving advances for Indian health, but these advances must come within the context of government-to-government relations between tribes and the United States and a reaffirmation of the trust responsibility that the federal government owes to the tribes. These are the fundamental principles on which any proposed plan must rest to properly address the health care needs of Indians."

Consideration of how the IHS and its facilities might coordinate with state health care reform proposals is not a straightforward exercise. The IHS is not a monolithic agency whose policies and programs are operated consistently throughout the country. Rather, it is a programmatic mechanism for fulfilling treaty obligations between the U.S. government and the sovereign tribal nations. This unique government-to-government relationship between the tribal nations and the U.S. government means that care must be taken when making broad generalizations about the IHS system under varying scenarios of health care reform.

In Montana, as in other states, the ultimate relationship of the IHS system to any state-level reform process will likely be the result of the interplay among several factors. Tribal responses to any proposed health care reform plan are likely to vary significantly from tribe to tribe within the state, owing to each tribe's local circumstances, culture, and historic relationship with the state. Overlaying all discussions of state health care reform as it relates to Indian people will be the tribe's interaction with the federal government. Decisions relating to the participation of the IHS in a

reformed health care system in Montana are but one aspect of the complex relationship between the state and tribal nations within its borders.

There are several issues and concerns from Indian people which require the Health Care Authority's consideration. Paramount among them is the need for the Authority to reassure Montana's Indian leaders that the intent of the recommendations contained in the discussion draft of its universal access plans report is not meant to divert IHS funds from their intended purposes in order to apply them elsewhere. New language contained in the October 1, 1994 version of the report is designed to correct earlier misunderstandings along these lines. The Authority's message has been to promote the concept of working with Montana's tribes by strengthening access to health care on and off the reservations by maximizing funds and resources in areas where the provision of or access to health care can be improved. By pooling purchasing power, efforts should result in the ability to gain more in health care benefits, concentrate more on preventive and primary care, and, most importantly, work to achieve appropriate and affordable health care for all individuals in Montana.

In addition to clarification of the recommendations in the universal access plans, the following have been identified as issues which health care reform efforts may be able to have some positive influence:

1. Tribal-operated, IHS-operated, and urban Indian health services need support in their efforts to improve health care access and quality for eligible individuals through infrastructure development, improved medical education opportunities for tribal members, increased emphasis on preventive and primary care services in cooperation with existing efforts through other public agencies, and by becoming certified for Medicare for payment of services in clinical settings.
2. Tribal-operated, IHS-operated, and urban Indian services need backing in efforts to promote logical delivery system redesign, resulting in the ability to offer quality health care which is more affordable to the tribes and to IHS. One example would be moving from a hospital designation to a medical assistance facility designation which still allows for cost-based reimbursement. Along with such a step may be encouragement to centralize health services to lower administrative costs. Also, the Authority should take steps to monitor the Confederated Salish and Kootenai health system demonstration project to see how such efforts might have positive impacts on health care reform initiatives elsewhere.
3. IHS benefits are at times either inadequate in what they will cover or result in instances where Indian residents go without coverage for their health care needs because of eligibility criteria. These problems need to be resolved.
4. Consideration should be given to Indian leaders' strongly expressed desire to allow traditional medicine as an option for any Indian resident who wishes to obtain such treatment. If such treatment is desired in an inpatient setting, Indian leaders believe it should be allowed as long as it can be demonstrated that no individual will be at risk as a result.
5. Indian leaders have stated a preference that managed care recommendations relative to IHS-eligible individuals remain optional to alternatives which recognize that some individuals within this population group are prone to migratory living patterns. Managed care options tend to work better for populations or purchasing groups which remain in static living arrangements on a more consistent basis.

There are other issues that the Authority intends to explore with the tribal leaders, urban clinic representatives, and the IHS. The need for the Authority, the State of Montana, the Indian Health Service, the tribes, and the urban clinics to improve relations through continuous and open communications has become evident. In particular, the Authority should take advantage of current efforts at the federal level to respond to health care reform concerns from Indian country. Dr. Philip Lee, Assistant Secretary of Health and Human Services, Dr. Margaret Currie, Region VIII HHS Director, Dr. Michael Trujillo, Director of the Indian Health Service, all have made special trips to Montana recently because of their interest and concern for the individuals their programs serve and their concern over how Montana's health care reform efforts might affect them. The Authority should continue its dialogue with these individuals and, most importantly, it should continue to seek advice and guidance from those who can best speak for Montana's Indians — Montana's Indians.

The Veterans Affairs System

The primary mission of the VA is to provide high-quality medical and ancillary services to eligible military veterans. Nationwide, the VA accomplishes its mission by operating 171 medical centers and over 300 clinics. In FFY 1992, the total budget for the VA medical system was nearly \$15 billion.

Montana's Veteran Population. According to the 1990 Census there were 102,000 veterans in the state of Montana. Only slightly more than 10 percent of Montana veterans (11,200) made use of the VA system in 1993, which is roughly the national average. Several factors account for this level of usage by Montana veterans:

- ***Accessibility.*** The three delivery sites operated by the VA are a considerable distance away from most Montana veterans.
- ***Alternative sources of care.*** Many veterans have private insurance coverage or sufficient resources and thus can easily seek care through non-VA providers.
- ***Eligibility.*** Priorities established by the VA system effectively exclude many veterans from receiving services through the VA.

Veterans Access to the VA Services. The VA system functions under yearly capped budgets which forces it to place restrictions on the amount of services it provides. To establish priorities, the VA uses the broad categories of discretionary and mandatory veterans, along with finer distinctions within the mandatory category.

- **Discretionary Veterans.** Veterans with no service-connected condition and whose income exceeds \$19,912 are considered "discretionary." If local resources permit, discretionary veterans may receive hospital services at VA facilities, although they will be responsible for a copayment (equal to the Medicare copayment of \$696). In 1993, less than three percent of the veterans who made use of the Montana VA system were classified as discretionary (VA Medical Care Fact Sheet - Eligibility).
- **Mandatory Veterans**
 - Veterans with a greater than 50 percent service-connected disability*** receive inpatient, outpatient, and pharmacy benefits through VA facilities without restriction (VA Medical Care Fact Sheet — Eligibility).

Veterans with a less than 50 percent service connected disability receive unrestricted hospital benefits and may receive outpatient services "to prevent the need for hospitalization; to prepare for hospitalization; or to complete an episode of treatment after hospitalization" (VA Medical Care Fact Sheet — Eligibility).

Low income veterans. Veterans with no service connected disability, whose income falls below \$19,912 for a single individual (the threshold is adjusted upward to account for family size), receive unrestricted hospital benefits and may receive outpatient services, "to prevent the need for hospitalization; to prepare for hospitalization; or to complete an episode of treatment after hospitalization" (VA Medical Care Fact Sheet — Eligibility).

Roughly 97 percent of the veterans using the Montana VA system in FFY 1993 were classified as mandatory. Approximately half of the mandatory veterans qualified on the basis of income, having no service-related condition. For these lower income veterans, the VA system may be serving as a limited benefit insurance policy. They are covered for hospitalization and acute conditions which may require hospitalization. They are not, however, covered for ongoing primary care for the management of chronic conditions such as hypertension or diabetes.

The Department of Veterans Affairs. In Montana, the VA operates two facilities:

- **Fort Harrison -- Helena:**

113-bed hospital

1993 occupancy rate: 69 percent

Outpatient department received over 37,000 visits

Served approximately 8,500 Montana veterans

- **VA Medical Center -- Miles City** (also operates a clinic in Billings):

40-bed hospital

1993 occupancy: 58 percent (the facility is authorized for 91 beds but only operates 40 at present)

26 long-term care beds (1993 occupancy rate: 96 percent)

Outpatient department (Miles City and Billings combined) received 25,586 visits in FFY 1993

Served approximately 3,700 Montana veterans

The total VA medical budget for the state of Montana (Fort Harrison and Miles City combined), was over \$37.5 million in FFY 1993.

VA Efforts to Work with State Health Care Reform. In response to state level health care reform initiatives such as Montana's, the VA has sought national legislation that would allow the it greater flexibility to work with such efforts. Under language proposed (but not enacted) in

the Veterans Health Improvement Act of 1994, the VA would have been allowed to identify up to five pilot states where it could have exercised greater latitude in addressing issues related to the integration of the VA system into a reformed state health care system. In particular, the VA is interested in contracting issues, both in terms of how it would contract for the services it would need to become a full service health plan, and how it might contract with health plans that wish to use VA facilities for veterans enrolled in their plans. Under the proposed legislation, the Secretary for Veterans Affairs would select pilot states based on the following criteria:

- The relative universality of coverage afforded state residents under a state's reform plan;
- The scope of health care benefits offered under the state's reform plan; and
- The extent of financing committed to support the state's plan.

The universal coverage plans to be developed by the Montana Health Care Authority have the potential to meet the VA's criteria as a pilot state for health reform if it ever receives the necessary congressional approval.

Under the single payer section of the statewide universal health care access plans, the Authority has recommended that "the state should . . . seek federal approval to incorporate funds used to provide services to Montana veterans through the Veterans' Administration program into the single payer system and to provide these veterans with coverage through the system." On the regulated multiple payer side, the Authority recommends that "[v]eterans receiving services through the VA system would have the option of electing to have those services deemed as meeting the individual coverage requirements." There are some issues which are similar to IHS issues, especially where a single payer option of health care recommends pooling of funds.

Individual veterans and veterans groups across the state have generally agreed that there are problems in the VA system which health care reform efforts may be able to address. A common concern of veterans implicated the current system of veterans health care. While many individuals were very critical of the system, in particular the complex and overly bureaucratic eligibility system, there were few recommendations to do away with services specifically for veterans. Even though the proportion of veterans who use the VA system remains low according the General Accounting Office, there is widespread belief that it is a system that could be improved. Many veterans, in fact, believe that national health care reform efforts has already led to system improvements since the VA has been put into an environment where it must be more competitive.

Conclusion

It is the Health Care Authority's belief that efforts to explore the appropriate and effective integration of these two programs into Montana's health care reform efforts should continue as system improvements are made. While full-scale integration may in the end not be called for, there is a strong belief that both veterans and Indian populations could very well end up with better health care services as a result of state level health care reform.

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**III. CLINICAL PRACTICE GUIDELINES
AS A MEANS OF REDUCING
DEFENSIVE MEDICINE IN MONTANA**



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THE FOLLOWING SUPPLEMENTARY INFORMATION RELATIVE TO THIS REPORT
IS AVAILABLE FROM THE HEALTH CARE AUTHORITY UPON REQUEST.

SUPPLEMENT A MAINE'S LEGISLATION

SUPPLEMENT B PRACTICE GUIDELINES USED IN MAINE'S MEDICAL
LIABILITY DEMONSTRATION PROJECT

SUPPLEMENT C MINNESOTA'S LEGISLATION

SUPPLEMENT D FLORIDA'S LEGISLATION

SUPPLEMENT E VERMONT'S LEGISLATION

REFERENCES

I. INTRODUCTION AND OVERVIEW

During the 1993 legislative session, the Montana General Assembly enacted Senate Bill 285, articulating the state's intention to "ensure that all residents have access to quality health services that are affordable." Toward that end, the legislature created the Montana Health Care Authority (MHCA) and directed it to develop two health care reform plans to achieve universal access: one based on a single-payer system and the other on a regulated multi-payer system. The MHCA was also asked to conduct a study exploring the use of clinical practice guidelines as a means of reducing defensive medicine. This document responds to that request by examining the following topics:

- The nature and causes of defensive medicine;
- The purpose and development of practice guidelines;
- The potential benefits and limitations of practice guidelines as a means of reducing defensive medicine;
- The experiences of other states with practice guidelines; and
- The policy and system design options available to Montana.

II. DEFENSIVE MEDICINE

According to the Office of Technology of Assessment (OTA), "defensive medicine occurs when doctors order tests, procedures, or visits, or avoid certain high-risk patients or procedures primarily (but not necessarily solely) because of concern about malpractice" (OTA, 1994). As this definition reflects, there are two types of defensive medicine: negative and positive. Negative defensive practices are those that physicians *do not* perform in order to minimize their risk of malpractice. For example, obstetricians/gynecologists who limit their practice to gynecology to avert the risk associated with performing deliveries are practicing negative defensive medicine. Positive defensive practices, in contrast, are those that physicians *do* perform in order to protect themselves from malpractice liability. These

activities may include ordering extra diagnostic tests, performing additional procedures, seeking outside opinions from consultants or subspecialists, scheduling additional follow-up visits, and spending extra time with patients (Rubin and Mendelson, 1994).

Both types of defensive medicine may have adverse consequences for the health care system. While negative defensive medicine may reduce access to services among populations considered to be high risk, positive defensive medicine is believed to be a hidden contributor to high and rising health care costs (OTA, 1994). This latter effect has proved difficult to substantiate. Studies conducted in 1984 by the American Medical Association's Center for Health Policy Research produced two estimates of the costs of defensive medicine: \$13.7 billion and \$12.1 billion. Using the methodology that produced the latter estimate, a study by Moser and Musaccio arrived at an updated figure of \$15.1 billion in 1989 dollars (Moser and Musaccio, 1994). Although these studies used fairly rigorous approaches in quantifying the financial burden of defensive medicine, an article in which they were reviewed points out that they have several methodologic flaws. The authors of this review concluded that these estimates are likely to overstate defensive medicine's true costs, but that they may represent the costs' upper bound (Rubin and Mendelson, 1994). The methodological difficulties encountered in these earlier studies were confirmed in a recently-released study conducted by the Office of Technology Assessment. The study attempted to measure the financial impact of defensive medicine more precisely, but found that "it is impossible to accurately measure the overall level and national cost of defensive medicine." Despite their inconclusive findings, the authors stated that "the evidence... implies that [defensive medicine] is neither a trivial nor a major contributor to health care costs" (OTA, 1994).

Over time, the term defensive medicine has acquired a negative connotation; nevertheless, not all defensive medicine is inappropriate. Rather, when physicians' concerns about liability lead them to practice more conscientiously, defensive medicine is desirable. In this situation malpractice law is accomplishing its intended purpose by serving as a deterrent to negligent care (American Bar Association, 1993). Defensive practices become inappropriate when they are of little or no added benefit to the patient or impose an additional medical risk.

As the term implies, defensive medicine is a defense mechanism used by physicians to protect themselves from a relatively litigious practice environment and an unpredictable legal system. Physicians' primary reason for practicing defensively is to reduce their risk of being sued. Although the incidence of medical malpractice claims peaked in 1985 and has been declining at an average annual rate of 8.9 percent since that time, the malpractice "crises" of the mid-1970s and 1980s left behind a pervasive fear of malpractice among physicians (ABA, 1993). This fear, while often exaggerated, is not unfounded. The number of claims filed against physicians covered by St. Paul Companies, the nation's largest malpractice insurer, was 13.9 per 100 in 1990, compared to 2.6 per 100 in 1974 (General Accounting Office [GAO], 1993). In addition, a survey of nonfederal patient-care physicians conducted in 1990 by the American Medical Association found that 39 out of every 100 respondents had had at least one claim filed against them. Among certain specialties, the proportion was even greater, with 57 percent of obstetricians/gynecologists and 53 percent of surgeons having been sued at least once (GAO, 1993).

Physicians may also practice defensively to improve their chances of successfully defending themselves in the event that they are sued. The current nature of the malpractice system precludes physicians from knowing beforehand the standards to which they will be held accountable if they are sued, contributing to their fear of malpractice and their adoption of defensive practices. In order to successfully sue for medical negligence, a plaintiff must prove the following four points:

- The provider owed a duty of care to the patient;
- The provider breached this duty by failing to provide care that met the applicable *standard of care* for that practitioner under the specific circumstances;
- The patient sustained compensable damages; and
- The physician's breach of duty was the proximal cause of those damages (OTA, 1994).

The standard of care is the measure used to evaluate the appropriateness of the defending physician's conduct. It is defined as "the degree of knowledge, skill, and care that would have been exercised by a competent physician under circumstances similar to those faced by the defendant physician" (Hirshfield, 1993). In malpractice suits, it is established on a case-by-case basis *after* a physician has been accused of malpractice. Expert testimony is the primary source of evidence used to determine whether or not a physician met the standard of care, but other sources of evidence, including practice guidelines, may be used to supplement this testimony. This somewhat vague standard by which physicians are judged may cause them to practice defensively in order to ensure a strong legal defense if they are sued.

In short, physicians' fears of being sued, exacerbated by their uncertainty regarding the standard of care, lead them to practice defensively. While the causes of defensive medicine are clear, the solution to the problem of inappropriate care is less so. Past efforts to reduce inappropriate defensive medicine have been limited to conventional tort reforms (i.e., changes in the legal rules for resolving malpractice claims), such as placing caps on malpractice awards, limiting attorneys' contingency fees, shortening the statute of limitations for malpractice claims, and requiring the periodic disbursement of awards. There is some evidence to suggest that these reforms reduce the number of malpractice claims, the amount of awards, and the cost of malpractice insurance. They may also reduce defensive medicine by diminishing the risk of malpractice; however, this effect has not been documented (OTA, 1994).

In addition to their uncertain effectiveness, traditional tort reforms have several other drawbacks as a means of reducing defensive medicine. First, to the extent that they reduce the fear of malpractice, conventional tort reforms will lead physicians to reduce both inappropriate and appropriate care that may be provided, at least in part, as a result of that fear. Second, while tort reforms may reduce the risk of being sued for malpractice, they do not address the uncertainty surrounding the standard of care which may also contribute to defensive medicine. Clinical practice guidelines may offer a better solution to inappropriate defensive medicine because they are without these shortcomings. Practice guidelines not

only have the potential to reduce the risk of malpractice suits, but also may target reductions in defensive medicine to inappropriate care and help establish a more explicit standard of care.

III. PRACTICE GUIDELINES

Practice guidelines, also known as practice parameters or protocols, are "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Field and Lohr, 1992). Practice guidelines are intended to improve health outcomes by serving as resources that can help providers and patients make informed decisions regarding the diagnosis, treatment, management, and prevention of medical conditions and diseases.

A. Guideline Development

Currently, there are approximately 2,000 practice guidelines in circulation nationwide (Leeds, 1994). They are developed by a variety of groups for a number of different reasons. Medical specialty groups are the original architects of practice guidelines. Some of these groups have been developing guidelines for over fifty years (Merz, 1993). According to a 1991 General Accounting Office survey of specialty societies, the two primary reasons these groups develop guidelines are: 1) to improve the quality of care and 2) to protect themselves against outside forces. This latter objective may include efforts to reduce malpractice and its related costs, promote uniformity in insurance coverage and utilization review, and counter guidelines produced by other specialty groups (Field and Lohr, 1992).

Practice guidelines are also developed by the federal and state governments. Guideline development became an official part of U.S. health policy in 1989 when the federal government amended the Public Health Service Act to create the Agency for Health Care Policy and Research (AHCPR). AHCPR's mission is to "enhance the quality, appropriateness, and effectiveness of health care services" (Merz, 1993). Within AHCPR,

the Office of the Forum for Quality and Effectiveness was established and given responsibility for the development and periodic review of practice guidelines (Merz, 1993). In addition, a number of states have enacted legislation relating to practice guidelines. Their objectives are similar to those at the national level. The different approaches being pursued by these states are discussed further in Section IV of this report.

Third-party payers also develop guidelines to facilitate coverage and payment decisions. Finally, research organizations and a variety of other professional groups contribute to guideline development to a lesser degree.

Just as these groups' purposes for developing guidelines differ, so too do the development processes they employ. Their guideline development methodologies may vary with respect to a variety of factors, including:

- Rigor of literature review;
- Source of professional opinions (e.g., national experts vs. local physicians);
- Formality of the group decision-making process; and
- Criteria used to evaluate the medical practices (e.g., medical effectiveness vs. cost-effectiveness (Audet, 1990).

Because no standard process for developing high-quality guidelines has emerged, there is a wide variation in the quality of guidelines produced by different groups. The Institute of Medicine (IOM) has identified eight attributes essential to good practice guidelines, including:

- Validity;
- Reliability/Reproducibility;
- Clinical applicability;
- Clinical flexibility;
- Clarity;
- Multi-disciplinary process;
- Scheduled review; and
- Documentation.

These attributes are defined in Table 1 on the following page. The Institute of Medicine has used these attributes to develop an instrument for assessing the quality of guidelines (IOM, 1992).

B. Potential Impact of Practice Guidelines on Defensive Medicine

Well-developed practice guidelines have the potential to reduce defensive medicine through a variety of direct and indirect channels. First, practice guidelines provide clear information as to what constitutes appropriate care in a specific medical situation, which, if followed, may help eliminate inappropriate care, including defensive medicine, from physicians' practices. Second, by improving the quality of care, practice guidelines could reduce the incidence of medical negligence and the number of malpractice suits, which in turn may reduce the litigiousness of physicians' practice environment and their motivation for practicing defensively.

One group that has already begun to recognize and take advantage of the potential of guidelines to simultaneously improve quality and reduce the claims and judgements against physicians is the malpractice insurers. Over a dozen liability insurers are currently using practice guidelines as a risk management strategy (i.e., a strategy to reduce physicians' risk of being sued). Most of these insurers are disseminating guidelines that they have either developed or endorsed to their physicians and are encouraging adherence to them through the use of incentives (e.g., reduced premiums). A few insurers have mandated compliance with guidelines as a condition of coverage. In these latter cases, if physicians unjustifiably deviate from the guidelines and are sued for malpractice, they may subsequently face a variety of punitive measures such as remedial training programs, financial penalties, and loss of coverage in severe cases (Oberman, 1994).

Table 1**Attributes of Good Practice Guidelines**

Validity	Practice guidelines are valid if, when followed, they lead to the health and cost outcomes projected for them. A prospective assessment of validity will consider the substance and quality of the evidence cited, the means used to evaluate the evidence, and the relationship between the evidence and the recommendations. In order to facilitate this assessment, practice guidelines should be accompanied by descriptions of the strength of the evidence and the expert judgement behind them, as well as by estimates of the health and cost outcomes expected from the interventions in question, compared with alternative practices.
Reliability/ Reproducibility	Practice guidelines are reproducible and reliable if: (1) given the same evidence and methods for guidelines development, another set of experts produces essentially the same statements and (2) given the same clinical circumstances, the guidelines are interpreted and applied consistently by practitioners (or other appropriate parties).
Clinical Applicability	Practice guidelines should be as inclusive of appropriately defined patient populations as evidence and expert judgement permit, and they should explicitly state the populations(s) to which statements apply.
Clinical Flexibility	Practice guidelines should identify the specifically known or generally expected exceptions to their recommendations and discuss how patient preferences are to be identified and considered.
Clarity	Practice guidelines must use unambiguous language, define terms precisely, and use logical and easy-to-follow modes of presentation.
Multi- Disciplinary Process	Practice guidelines must be developed by a process that includes participation by representatives of key affected groups. Participation may include serving on panels that develop guidelines, providing evidence and viewpoints to the panels, and reviewing draft guidelines
Scheduled Review	Practice guidelines must include statements about when they should be reviewed to determine whether revisions are warranted, given new clinical evidence or professional consensus (or the lack of it).
Documentation	The procedures followed in developing guidelines, the participants involved, the evidence used, the assumptions and rationales accepted, and the analytic methods employed must be meticulously documented and described.
Source: Institute of Medicine, 1992	

Finally, practice guidelines could reduce defensive medicine by helping to resolve the ambiguity over the legal standard of care within the malpractice system. By making practices more uniform and helping to clarify what constitutes appropriate care, practice guidelines could remove some of the uncertainty that leads to defensive medicine. Furthermore, if over time guidelines gain greater use and/or increased legal status as evidence of the standard of care in legal proceedings, they may increase physicians' confidence in their legal defense, thereby diminishing the perceived need to practice defensively. While the potential exists for the use of practice guidelines to reduce the extent to which defensive medicine is practiced, there are a number of factors, both inherent and external to guidelines, that could possibly reduce their impact.

C. Possible Limitations of Practice Guidelines as a Means of Reducing Defensive Medicine

A number of factors may limit the extent to which practice guidelines are adopted into medical practice and used in the malpractice litigation, thereby diminishing their effectiveness as a means of reducing defensive medicine. As indicated in Table 2, these factors include certain characteristics of guidelines themselves, as well as factors related to the practitioners and patients for whom guidelines are intended, and the legal system in which they may serve as a source of evidence of the standard of care.

1. Characteristics of Guidelines

Guidelines have several characteristics that may affect their usefulness as a means of reducing defensive medicine. First, the specificity of guidelines will affect the degree to which they help reduce malpractice litigation. The more specifically a guideline delineates appropriate care, the more useful it will be in clarifying the legal standard of care. Most guidelines that have been developed to date offer recommendations that leave considerable leeway for practice variations based on professional judgement. While this flexibility may be an advantage in terms of the provision of medical care, it may preclude guidelines from

helping to pinpoint the standard of care and from removing the uncertainty that contributes to defensive medicine (OTA, 1994).

Second, the range of guidelines may not be comprehensive enough to significantly affect defensive medicine. Although the number of guidelines has grown dramatically in recent years, the number of conditions and procedures for which guidelines exist is still relatively small. Even if guidelines do reduce defensive medicine in the areas in which they exist, their overall impact may be limited. This limitation may be overcome if guidelines are targeted to practice areas in which defensive medicine is relatively common.

Third, the existence of guidelines that set conflicting standards could undermine their use in court if judges and juries are unable to distinguish between good and bad guidelines, choosing instead to disregard them. Fourth, the source of guidelines and the process used to develop them will also affect their impact on defensive medicine. Guidelines produced by reputable organizations are more likely to be followed by physicians and more likely to be used as evidence in court than those produced by lesser-known entities. Guidelines produced by a rigorous development process are similarly more likely to be adopted and used in court.

Finally, the criteria used to determine the practices included in the guidelines will affect their use in malpractice proceedings. For example, guidelines that factor cost-effectiveness into decisions regarding appropriateness of care are unlikely to hold much weight in the current malpractice system that does not consider cost to be a valid basis on which to ration medical care.

2. Factors Related to Physicians and Patients

There are also factors relating to the users of guidelines, namely physicians and their patients, that will affect their impact on defensive medicine. If physicians are unaware of guidelines or unwilling to follow them, then their effectiveness will be a moot point. Physicians' willingness to adhere to guidelines may be governed by their patients' demands

Table 2**Possible Limitations of Using Practice Guidelines
as a Mechanism for Reducing Defensive Medicine**

Characteristics of Guidelines	Factors related to Physicians and Patients	Factors related to Legal System
<ul style="list-style-type: none">■ Recommendations may be too broad to be a useful source of evidence of standard of care.■ Range of situations addressed by guidelines may be too small to have a significant impact regardless of their effectiveness (unless targeted to areas with a high degree of defensive medicine).■ Intensive development and review processes may prevent guidelines from keeping pace with medical advances.■ Existence of conflicting guidelines may undermine their usefulness as a source of evidence of standard of care.■ The use of certain criteria in guideline development, especially cost-effectiveness, and lack of rigorous development processes may reduce their legitimacy as evidence of the standard of care.■ The source and intended purpose of guidelines (i.e., third party payers & cost containment) may limit their legitimacy as evidence of the standard of care.	<ul style="list-style-type: none">■ Physicians and patients may not be aware of guidelines.■ Patients may demand services not specified in guidelines.■ Physicians may not have confidence in the protective effect of guidelines.■ Physicians may resist adopting guidelines.	<ul style="list-style-type: none">■ Guidelines are generally barred as evidence of the standard of care.■ The legal status of guidelines is subordinate to expert testimony.■ Courts are unwilling to accept cost-effectiveness in establishing standard of care.■ Judges lack of familiarity with guidelines may discourage them from allowing the admittance of guidelines as evidence of the standard of care.

Source: Adapted from OTA, 1994

for services, which may or may not parallel those recommended by the guidelines, as well as by the extent to which they believe that guidelines provide a useful protection in malpractice suits (OTA, 1994). Physicians' concerns in this area are likely to be heightened by the results of an upcoming study conducted by Harvard researchers which reveals that guidelines are more often used by plaintiffs against physicians than in their defense (cited in Oberman, 1994). As will be discussed in the following section of this report, several states (e.g., Maine and Minnesota) have perhaps anticipated the reticence that such a situation might generate in the physician community, and have established malpractice reforms that restrict the ability to introduce guidelines as evidence in malpractice proceedings to defending physicians.

3. Factors Related to the Legal System

The extent to which practice guidelines are admitted into court as evidence of the standard of care, the party by which they are introduced, and the legal weight they carry will all influence their impact on defensive medicine. Currently, the subordinate legal status of guidelines in malpractice proceedings limits the degree to which the potential benefits described above can be realized. Practice guidelines are usually barred as evidence under the "hearsay rule," which prohibits the introduction of out-of-court statements as evidence. They may, however, be admitted under the "learned treatise" exception to that rule if they are "established as a reliable authority by the testimony or admission of the witness or by other expert testimony or by judicial notice" (Runkle vs. Burlington Northern, 1980). If guidelines are admitted as evidence of the legal standard of care, they must be incorporated into expert testimony and remain subordinate to that testimony.

Currently, practice guidelines play a fairly marginal role in malpractice litigation. A national

review of all published court opinions between 1980 and 1993 uncovered only 32 cases in which practice guidelines were used as evidence of the standard of care (cited in OTA, 1994). To date, there does not appear to have been any cases in which practice guidelines were admitted as evidence under the "learned treatise" exception in Montana (Hill, 1994; Baker, 1994).

An additional factor limiting the use of guidelines in legal proceedings is judges' lack of familiarity with them as a source of evidence. A 1992 survey of state trial and appellate judges found that they ranked practice guidelines third among 30 scientific subjects on which they need more information (OTA, 1994). Despite these possible limitations, a number of states are pursuing practice guidelines through legislation in the hope that they will bring about a variety of positive changes in their health care systems.

IV. STATES' APPROACHES TO PRACTICE GUIDELINES

Approximately 20 states have been trying to hasten the benefits to be derived from practice guidelines by enacting legislation relating to their use. These states are pursuing guidelines in order to achieve multiple objectives, including cost containment, quality improvement, and reductions in malpractice suits and defensive medicine. The four main policy strategies utilizing practice guidelines to accomplish these ends are identified below.

First, four states (Iowa, New Jersey, Rhode Island, and Wisconsin) have passed legislation similar to Montana's that mandates studies of the use of practice guidelines in different capacities. Second, a few states are promoting the use of already existing guidelines. For example, Utah is pursuing a demonstration project that explores ways of getting physicians to voluntarily adopt guidelines, and Arkansas applied for a grant from the Robert Wood Johnson Foundation to fund the dissemination of the American Academy of Pediatrics' guidelines to the state's pediatricians (Leeds, 1994).

Third, about ten states have directed or encouraged the development of practice guidelines. Most of the states pursuing this approach assign responsibility for guideline development to an existing or newly-established government or quasi-government agency (e.g., New York State Task Force on Clinical Guidelines and Medical Technology, Florida Agency for Health Care Administration, Minnesota Practice Parameter Advisory Committee). These groups may actually develop guidelines from scratch, they may choose to modify or adopt those produced by another source, or they may do a combination of both. Some of these legislative initiatives relating to guideline development give general directives, while others specify areas in which guidelines should be developed based on criteria that are important to the state, such as high cost, high incidence of malpractice litigation, or public funding source. A few examples of these targeted guideline initiatives are provided below:

- Florida specified that guidelines should be developed for resource-intensive procedures, including diagnostic imaging centers, radiology therapy units, and comprehensive rehabilitation centers;
- Florida also mandated the development of practice guidelines for physicians performing caesarean sections for state and federal funded deliveries;
- Michigan mandated the development of guidelines for life support agencies and emergency medical services; and
- Maryland directed the development of practice guidelines for physicians infected with HIV (Leeds, 1994).

Some of the states that are developing practice guidelines are also experimenting with them as instruments of malpractice reform. Maryland presents a unique case in that it mandates the development of practice guidelines in areas subject to a significant amount of malpractice litigation, but prohibits their use as evidence in legal proceedings. In contrast, Minnesota, Florida, Kentucky, and Vermont have all taken legislative measures to facilitate the use of guidelines as evidence in establishing the standard of care in malpractice proceedings. One objective of this latter strategy is to establish a more reliable legal environment in order to encourage physicians to eliminate inappropriate defensive medicine from their practices. The following case studies describe this last approach in greater detail.

A. Maine

Maine is at the forefront of practice guideline legislation. In 1990, the state passed legislation initiating a five-year Medical Liability Demonstration Project. A copy of this legislation is provided in Appendix A. The project's goals include:

- Reducing malpractice suit rates and insurance premiums;
- Reducing defensive medicine;
- Reducing variation in practice patterns; and
- Containing overall health care costs.

To accomplish these goals, the statute authorized the development of practice guidelines that would be given increased legal status in malpractice proceedings. Specialty advisory committees were established to develop guidelines in four specialty areas where defensive medicine was considered to be exceptionally pervasive, including: emergency medicine, obstetrics/gynecology, anesthesiology, and radiology. A complete set of these guidelines is included in Appendix B. One stipulation of the project was that before it could be implemented in any of these specialty areas, 50 percent of the physicians in that field had to agree to participate.

Maine's legislation allows physicians participating in the project to use compliance with the state-developed guidelines as an affirmative defense in malpractice trials and pretrial hearings. An affirmative defense is "a response by a defendant in a legal suit which, if true, constitutes a complete defense against the plaintiff's complaint" (OTA, 1994). Therefore, to prove medical negligence, a plaintiff must now either show that the physician did not adhere to the guideline or that the use of the guideline was inappropriate given the patient's medical condition. This change in the legal status of guidelines is intended to remove the uncertainty surrounding the standard of care that contributes to defensive medicine. In addition, the legislation reserves the right for defending physicians to introduce guidelines as evidence. This was done to allay physicians' fears that the existence of practice guidelines would increase rather than decrease the number of malpractice claims against them.

Although the project is still under way, preliminary evidence suggests that it is achieving its objectives. An indication that the project may have reduced the incidence of malpractice litigation is evidenced by the absence of claims filed with the state's leading malpractice insurer in the three and a half years since the project's inception (Atchinson, 1994).

Furthermore, the project appears to be having a positive impact on defensive medicine. The treatment of asymptomatic head injuries demonstrates this effect. The Medical Specialty Advisory Committee on Emergency Medicine developed and disseminated a practice guideline governing the use of cervical spine x-rays for acute trauma patients. In addition to giving directions on how to appropriately perform this procedure, the guideline clearly articulates conditions under which these x-rays are not medically indicated. Prior to the project, 90 percent of all patients experiencing a significant fall or car accident received a cervical spine x-ray. This proportion has fallen to 50 percent in the wake of the guideline's dissemination and adoption. Early results such as this, which are considered positive trends, led the state legislature to expand the project to additional specialties in 1993 (Vibbert and Reichard, 1993).

B. Minnesota

The Minnesota legislature followed Maine's lead by incorporating practice guidelines into its health care reform package. The MinnesotaCare Act enacted in 1992 and amended in 1993 established a Practice Parameter Advisory Committee (PPAC) and charged it with the development, adoption, revision, and dissemination of practice guidelines. A copy of this legislation is attached in Appendix C. This law also significantly increases the legal status of guidelines, by making those endorsed by the State Commissioner of Health an absolute defense against charges of medical negligence. This means that in order to successfully defend themselves against malpractice suits, physicians need only to prove that they adhered to an applicable practice guideline (Minnesota Practice Parameter Advisory Committee, 1994). As is the case of Maine, the right to introduce practice guidelines as evidence in a malpractice hearing is reserved for the defending physician. This project is still in its

preliminary phases. Currently, expert panels are in the process of reviewing guidelines and making recommendations to the PPAC and the Commissioner of Health as to whether they should be adopted. To date, none have been officially endorsed (Gifford, 1994).

C. Florida

In 1992 and 1993, Florida passed health care reform legislation that includes a hybrid of the two approaches described above. A copy of this legislation is provided in Appendix D. As in Minnesota, the legislature directed the Agency for Health Care Administration (AHCA) to coordinate the development, endorsement, and implementation of practice guidelines, concentrating its initial efforts on especially costly and common procedures (Vibbert and Reichard, 1993). In addition, the legislation called for the establishment of a demonstration project similar to Maine's to evaluate the impact of practice guidelines on defensive medicine and professional liability insurance. This demonstration project allows participating physicians to use adherence to practice guidelines as an affirmative defense. AHCA is responsible for evaluating the project and making recommendations to the legislature as to whether the affirmative defense should be extended to all Florida physicians.

D. Kentucky

Kentucky passed legislation in 1994 mandating the Health Policy Board to develop and implement practice guidelines. As in the cases discussed above, Kentucky increased the legal weight of practice guidelines in establishing the legal standard of care, but to a somewhat lesser degree. Under this system, physicians charged with malpractice can use compliance with practice guidelines as a rebuttable presumption in malpractice proceedings. This means that the defending physician is presumed to have met the standard of care unless the plaintiff can provide proof to the contrary (Black, 1990).

E. Vermont

Vermont enacted health care reform legislation in 1992, Act 160, that created the Vermont Health Care Authority (VHCA) and directed them to develop two universal access plans. The VHCA was also authorized to oversee the development of practice guidelines to promote quality, patient satisfaction, and efficiency within the health care system. Currently, VHCA-sponsored guideline development is still in the conceptual phase; no formal activity has yet taken place.

Act 160 further provides that upon the enactment of a universal access plan, practice guidelines developed by professional provider organizations, licensed hospitals, or quality assurance programs recognized by the state can be admitted as evidence of the standard of care in a new mandatory arbitration process established for medical malpractice cases (Vermont Health Care Authority, 1993). The evidentiary weight of practice guidelines in these pretrial hearings would be no greater than that of expert testimony and the introduction of guidelines would not be restricted to the defense, but open to either party. Because these changes are conditioned on the adoption of universal access which has not yet been passed, they have not been implemented (O'Donnell, 1994). A copy of the enabling legislation for both of these initiatives is attached in Appendix E.

V. MONTANA'S POLICY OPTIONS

Because these state experiments with practice guidelines are still in their infancy, it is too early to tell which approaches, if any, are successfully reducing defensive medicine. Therefore, for the time being, Montana must consider its policy options based upon the potential benefits of guidelines, but in the absence of any solid evidence proving or disproving their effectiveness. The state could pursue a variety of different strategies depending on how active it wishes to be in this arena. These strategies are summarized below.

A. "Watchful Waiting"

Adopting a strategy analogous to the "watchful waiting" strategy used in medicine would enable Montana to closely monitor other states' experiences with guidelines and follow the natural progression of practice guidelines within the medical and malpractice systems before determining if any further action is appropriate. This strategy could also incorporate efforts to increase the awareness of practice guidelines among physicians and their patients in order to overcome some of the less severe limitations to the use of practice guidelines mentioned above.

B. Promote Development, Dissemination and Utilization of Practice Guidelines

Montana could opt to promote the development, dissemination, and utilization of guidelines within the state without altering their legal status in malpractice proceedings. This approach is based on the assumption that in spite of their subordinate status in the current legal system, as practice guidelines become a more regular feature of the medical system, they may help reduce defensive medicine by clarifying the standard of care (OTA, 1992).

One drawback of this strategy is the considerable cost associated with the development of high quality guidelines. The 1991 General Accounting Office survey of medical specialty societies found that the estimated cost of developing a single guideline or set of guidelines, excluding volunteer time, ranged from \$5,000 to \$130,000. One specialty society estimated that the value of volunteer time over a two year period was more than \$500,000. A directory of guidelines produced in 1991 reported an even wider range of cost estimates, spanning from a few thousand dollars to over \$1 million (cited in IOM, 1992). As a point of comparison, the development of a number of AHCPR's most scientifically rigorous guidelines have exceeded \$1 million each. While these costs may not be significant in comparison to the cost savings that could accrue through the development of guidelines that reduce the level of inappropriate or ineffective care, they nevertheless represent a substantial front-end investment. Most states that are attempting to develop guidelines are trying to

reduce these development costs by focusing on the adoption and/or modification of guidelines already in existence.

C. Change the Rules of Evidence

The State Supreme Court could amend the rules of evidence through an administrative procedure to exempt certain guidelines from the "hearsay rule" (Baker, 1994). This would allow practice guidelines to be used as one source of evidence of the legal standard of care, but one that carries no greater weight than expert testimony. A guideline's validity and applicability to the situation could still be challenged.

D. Increase Legal Status of Practice Guidelines

Finally, Montana could join the handful of states that are pursuing an aggressive approach to practice guidelines by increasing the evidentiary weight of guidelines in order make the legal standard of care in malpractice cases more explicit. This strategy seeks to encourage physicians to adopt guidelines by making compliance with guidelines a strong legal defense. If Montana chooses to pursue this strategy, it will need to make the following decisions regarding its implementation described below and in Table 3.

■ *How much legal weight will guidelines be assigned?*

The evidentiary weight of guidelines can be increased to differing degrees. First, adherence to practice guidelines can be made a rebuttable presumption, which means that the defendant is presumed to have met the standard of care unless the plaintiff can provide proof to the contrary (Black, 1990). The state could go further and make guidelines conclusive evidence of the standard of care. This means that if an applicable guideline was followed, the standard of care is presumed to have been met and the physician cannot be found negligent. It should be noted that while elevating the legal status of guidelines may help reduce and resolve claims, it would not mean the end of malpractice suits. There would still be claims filed on the basis of whether or not the guideline was followed, and whether or not the guideline was appropriate to the given medical situation.

Table 3

Options for Recognizing Practice Guidelines in Medical Malpractice Law

Weight

1. A guideline provides conclusive definition of an applicable standard of care
2. A guideline raises a rebuttable presumption; proof to counter this presumption can be offered
3. A guideline can be considered as some evidence of an applicable standard of care

Source of Recognition

1. Legislation
2. Administrative rulemaking
3. Judicial precedent

Authoritative Status

1. Guidelines developed by a specific entity are authoritative
2. Guidelines developed according to a specified criteria are authoritative
3. Judges have case-by-case discretion to determine whether a guideline is authoritative
4. Juries can decide as a matter of fact whether a guideline is authoritative

Right to Use

1. Only the defendant(s) can cite and use guidelines as a "shield" to claim immunity from liability for care delivered in accordance with guidelines
2. Only the plaintiff(s) can cite and use guidelines as a "sword" to claim malpractice for defendant failure to deliver care in accordance with guidelines.
3. Both defendant(s) and plaintiff(s) can cite guidelines

Source: Adapted from the Institute of Medicine, 1992

- *How will guidelines be recognized?*

Practice guidelines with increased legal status could be acknowledged through separate channels: they could be endorsed by the state legislature or by an authorized body (e.g., MHCA) through administrative rulemaking; or they could be acknowledged on a case-by-case basis through judicial precedent (Field and Lohr, 1992; Baker, 1994).

- *Which practice guidelines will be given authority?*

The state will need to determine which guidelines will be granted increased legal status. This determination could be made based on the entity that develops them (e.g., AHCPR or state-developed guidelines); or the methodology used to develop them (e.g., comprehensive literature review, national expert opinion, and formalized group decision-making process). This decision could also be left to the discretion of the presiding judges or to the juries (Field and Lohr, 1992).

- *Who can introduce guidelines?*

There are three options concerning who has the right to introduce practice guidelines into malpractice proceedings. It can be reserved for the defendant, in which case it serves as a "shield" against malpractice liability when care was delivered in accordance with guidelines. It can also be reserved for the plaintiff, serving as a "sword" in a malpractice claim used to show that a physician failed to meet the standard of care laid out by the guidelines. Finally, the state could choose to allow practice guidelines to be introduced by either party (Field and Lohr, 1992).

VI. VIEWS OF KEY MONTANAN CONSTITUENCIES

The views of some of the key Montanan constituencies affected by practice guidelines reveal that the political atmosphere in the state may support a relatively conservative approach at this time. Discussions with the Montana Medical Association and the Montana Trial Lawyers Association indicate that these groups appear to support the wider implementation of practice guidelines to some degree, but that they have a number of reservations about how they will be used, the effects they will have, and the resources they will require.

Both of these groups are currently in opposition to making guidelines conclusive evidence of the legal standard of care. They also voiced several other concerns, including:

- Practice guidelines may lead to "cookbook medicine," oversimplifying the skill and art needed to diagnose and treat patients;
- Practice guidelines may discourage the innovation that leads to medical and technological advances;
- The science of guideline development is not far enough along to ensure the production of high-quality guidelines; and
- The laborious development process may preclude guidelines from keeping pace with medical advances (Zins, 1994 & Hill, 1994).

In short, these groups believe that the pursuit of guidelines through a legislative initiative may be premature at this time given the lack of evidence as to their effectiveness and the significant costs associated with their development. They believe that Montana should monitor and learn from the experiences of other states prior to undertaking their own initiative.

VII. SUMMARY AND CONCLUSION

Defensive medicine presents a challenge to Montana policymakers because it may limit access to and increase the cost of health care, two effects that are antithetical to the state's goal of providing affordable health care to all of its residents. Practice guidelines present one potential means of reducing defensive medicine. They hold more promise than traditional tort reforms, because in addition to reducing physicians' risk of being sued for malpractice, they target inappropriate care and may help address the uncertainty surrounding the legal standard of care. Practice guidelines may reduce defensive medicine both directly and indirectly by changing physicians' practice patterns, as well as by creating a less litigious and ambiguous medical-legal environment. However, the ability of practice guidelines to

achieve these anticipated results and the expected cost savings is equivocal. According to Marilyn Field, Study Director of the Institute of Medicine's Committee on Clinical Practice Guidelines:

the net impact of practice guidelines on total health care costs cannot be predicted with confidence. Good guidelines if implemented should improve the value of spending on health care, but the net impact on overall costs is uncertain (Field, 1993).

Given the uncertain magnitude of the costs and consequences of defensive medicine, as well as the unknown effectiveness of practice guidelines at reducing defensive practices, no single policy strategy can be identified as most appropriate at this time. Rather, there are several legitimate strategies that Montana could pursue depending on how active it wishes to be and how much confidence it has in the future of practice guidelines. These strategies range from monitoring other states' experiences with guidelines and following their natural evolution in the medical and legal systems, to increasing the legal status of guidelines to give them a greater role in malpractice proceedings. For the time being, policy decisions regarding practice guidelines should be made while considering guidelines' potential to reduce defensive medicine and its associated costs, and to improve the quality of medical care, as well as their possible limitations and negative side-effects.

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IV. PUBLIC HEALTH IMPROVEMENT PLAN

PUBLIC HEALTH IMPROVEMENT PLAN

A Proposal

To

The Montana Health Care Authority

Submitted

By

Montana's Committee for Improving Public Health

"If a fundamental purpose of health care reform is to advance the health status of Americans – not merely to improve the financing of medical treatment – careful attention must be given to strengthening the population-based prevention and public health programs of the Nation." United States Department of Health and Human Services, in "Health Care Reform and Public Health"

August 15, 1994

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ABSTRACT

This proposal, submitted by Montana's Committee for Improving Public Health, advocates strengthening our public health system. Attention to public health is a necessary complement to our state's health care reform efforts if the Authority's proposed guiding principle to "improve the health status of (Montana's) population" is to be realized.

The health of Montana's citizens is largely dependent on an inextricable relationship between our medical care system and our public health system. Medicine has the important role of treating illness and injury in individuals and employing clinical preventive procedures and individual education to prevent, detect, and treat disease as early as possible. Public health has the distinct role of monitoring for health threats to the overall population and employing population-based strategies to prevent them before they become a burden to society and the medical care system. This role is particularly important in the face of today's chronic diseases and causes of injury which largely stem from lifestyle issues and, by their nature, fall substantially outside the influence of the medical care system.

The debate on health care reform has revealed the need to focus our efforts earlier in the continuum of care by assuring access to primary care measures and reducing demand for expensive secondary and tertiary care. This proposal advocates taking this directional shift one valuable step further by bolstering the population-based services of public health. Public health's unique functions take place right where the health problems of today take root -- in our communities, workplaces, daycares, homes, and schools. As much as 70% of early deaths in this country (50% attributable to behavioral causes and 20% attributable to environmental causes) could be influenced by public's health most primary forms of prevention. Yet our "pay later" approach to health care, in which we spend only one penny per dollar on population-based prevention services (which have the lowest per capita cost), leaves us with a bill for prevention failures that devours 53% of our health care dollar. Not a wise investment strategy.

The call for addressing our public health system is compelling. The role of public health is recognized by the Authority in its guiding principles, identified by Regions II, IV, and V as a resource priority, and prevention is rated by the public, at the electronic forums, as the top goal of health care reform. The results of a recent survey of public health experts in communities across our state, reported herein, adds urgency to this call.

Specifically, the proposal is two-fold. First, it presents a plan for building our capacity to use health status data. It proposes making small grants available, one to a region, for start-up projects, and using these to demonstrate the utility of health status data in local or regional planning. Secondly, it sets forth a process, similar to one underway in Washington state, for examining, standardizing, and bolstering our public health infrastructure in communities across the state. In this process, a task force, appointed by the Governor, would take responsibility for drafting a "Public Health Improvement Plan" over a fifteen-month period and reporting its recommendations to the 1997 Legislature. The public health professionals and others appointed to the task force would serve as volunteers, supported by consultants and funds to reimburse travel expenses. Total budget request to support both aspects of the proposal over the fifteen-month period is \$219,880.

This proposal represents the first, important step in answering the call to strengthen public health. Montana's Committee for Improving Public Health sincerely puts forth this proposal and commits its support to seeing it through. We respectfully request that the Authority forward this proposal to the Legislature with a strong recommendation for its passage.

PUBLIC HEALTH IMPROVEMENT PLAN

*A Proposal to the Montana Health Care Authority
August 15, 1994*

PURPOSE

This proposal advocates strengthening Montana's public health system for the purpose of improving the overall health of Montana's citizens. The proposal is designed to complement Montana's health care reform efforts by assuring that the most primary forms of prevention -- population-based public health services -- are well in place across our state. Specifically proposed at this first stage in the process is a two-part plan to:

- 1) strengthen the infrastructure of essential public health functions at the local level; and
- 2) develop a health status data base to serve the state and local level in planning.

STATEMENT OF NEED

The Status and Cost of Our Health

As many as 70% of early deaths could be prevented by public health and prevention measures, according to the United States Department of Health and Human Services (DHHS). Figures released by DHHS further reveal that 53 cents of every health care dollar is spent treating preventable conditions. Yet we invest only one penny per dollar on preventive activities that could yield tremendous cost savings such as: stopping smoking among pregnant women which could save six dollars for every one spent; fluoridating water which, for one person's lifetime, costs the equivalent of one trip to the dentist's chair; and preventing the spread of HIV which could save an estimated 15 to 25 dollars for every dollar spent.

In the face of statistics such as these, the health care reform debate has, quite accurately, emphasized prevention. However, the discussion around prevention is most often limited to improving access to medical procedures, such as mammograms, physicals, pap smears, and colorectal exams, that are designed to detect diseases early. These clinical methods are valuable, but to get the most out of our prevention dollar we must invest in measures that actually prevent the disease in the first place.

The Essential Role of Public Health

Methods to bring about this "primary" form of prevention exist, rather uniquely, in the realm of public health. Many of the sweeping improvements in health status that have occurred over the past century-and-a-half were brought about largely by the prevention and population-based focus of public health. During this time, for example, maternal-child efforts including home visiting, prenatal and parenting education, mass immunization programs and the Women Infants and Children Nutrition Program (WIC) contributed greatly to reducing by 25% the overall death rate of our nation's children. A dramatic local example of the strength of these measures is demonstrated by the success of Missoula's public health prenatal effort in reducing the low birth weight rate among high-risk women from 13% when the program started in 1985 to the current 6% -- a rate better than Missoula's overall population of childbearing women.

Modern-day public health measures are of particular importance when one considers that the roots of today's diseases and deaths are significantly behavioral and, by their nature, fall largely outside the influence of our medical system. In fact, the Journal of the American Medical Association recently reported that a full 19% of deaths are caused by tobacco; 14% by poor diet and exercise habits; and 5% by alcohol. Measures to address these problems must take place where behaviors are learned -- in our communities, our schools, our homes, our environment, and our workplaces. In short, in public health's back yard.

Regardless of the setting or the public health issues, the role of public health has remained the same over time. Its mission is "to assure conditions in which people can be healthy" -- a societal charge that is quite distinct from that of our medical care system. Its basic process of assessing, developing policy, and assuring healthy conditions, whatever they may be, is a multi-purpose tool that has adapted over time to address evolving public health threats. Witness the reductions in stroke, heart disease, and motor vehicles deaths, for example, that have been realized as public health re-tooled to combat today's diseases.

In the last two decades, however, public health has struggled with issues that strain its very foundation. Public health's success in turning the tide in the battle against communicable disease, quite ironically, bred complacency about the need for public health's unique functions of vigilance and call to action -- its role as the protector or "immune system" of the entire population. Simultaneously, public health strained to be the safety net for an epidemic of individuals unable to gain access to an overburdened medical care system. As a result, public health has a weakened grasp on its core functions and an often mistaken identity as the provider for the underserved -- a dangerous distraction from its charge to protect the health of all.

The Status of Montana's Public Health System

A Summary of the "Adequacy of Public Health Core Functions In Montana Counties" Survey

In 1988, a committee of the Institute of Medicine that had convened around the concern that "the nation has lost sight of its public health goals and has allowed the system . . . to fall into disarray", reported their fears confirmed. A local look at the adequacy of core functions in communities across Montana provides little to counter this finding.

The core functions of public health, are by definition, essential. They mimic the functions of the immune system; to monitor and respond to health threats. To assure healthy conditions for all, a community must be able to monitor the health status of its population, identify health threats and problems, and mobilize forces to address these threats. While the shape these functions take varies from community to community, services are generally arranged around environmental protection, public health nursing services and maternal child health programs, communicable disease control, and chronic disease and injury prevention or healthy lifestyle promotion. "Adequacy of Public Health Core Functions in Montana Counties" a 1994 survey of local health officials, conducted by the Missoula City-County Health Department in consultation with the Montana Department of Health and Environmental Sciences, provides an estimation of the strength of core public health functions across our state.

Methods

Local public health officials in all 56 counties were asked to estimate the adequacy of nine core functions in their county. Fifty of 56 counties responded representing 89% of all counties and 95% of the state population.

Adequacy was rated in quartiles with the first quartile being the weakest representing, 0 to 24% adequacy; the second quartile 25 to 49%; the third 50 to 74% and the strongest rank of adequacy being the fourth or top quartile representing 75 to 100% adequacy. Each core function had sublistings of related services that, when rated and averaged, provide the overall estimation of adequacy for that core function. For example, the core function of Preventing Epidemics had sub-categories for services such as immunization campaigns and clinics, tracking reportable diseases, and AIDS prevention activities. Because the activities of public health can fall in many arenas and vary from community to community, respondents were asked to respond if the service or function was present, regardless of whether their department provided it.

In keeping with public health's charge to look at the whole population, results are reported by population but also plotted geographically. The tool was compiled from public health functions identified by DHHS, the National Association of County Health Officials, and the American Public Health Association. It was tested in Region V during May and conducted state-wide during June and July, 1994.

Summary of Results

The following pages summarize and illustrate the survey results. The first section reports the findings summarized by population so that we can see what percentage of the state's population that lives at various levels of adequacy for each of the nine core functions. Red and yellow is used to illustrate the lowest two (weakest) quartiles, and green and blue the two stronger quartiles.

The second set of charts summarizes the responses by region. It shows the average adequacy of each of the nine core functions within each of Montana's five health planning regions. The same color scheme is used. Results in this section are averaged and reported geographically, not compiled by population.

Also, a set of maps reported each county's response and the survey tool is included in the appendix.

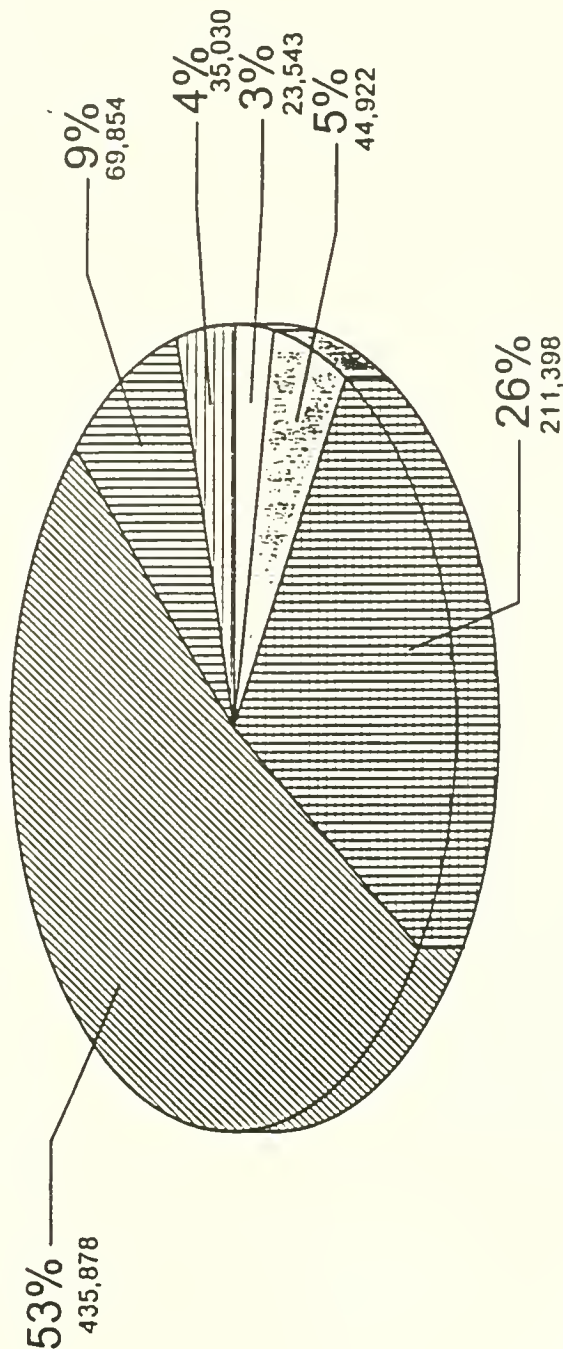
As the charts illustrate, most of the core functions summarized by population were rated at levels of less than half adequate or slightly better. Across the five regions, on the geographical plotting, the majority of the core functions were rated as less than half adequate.

This survey does not provide the scientific ground to tell us precisely the degree to which we fall short of DHHS's goal to "increase to at least 90 per cent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health"; a problem in itself. But it loudly sends a warning from the experts in the field to more closely examine this arena whose stewards, independently and consistently, rate as falling short, often by half.

Closer measures of the public health system and the public's health, itself, are clearly in order. Because of the status of the public health infrastructure in Montana, however, such measures are not yet available to us. They could be, though, if we chose to reach.

PREVENTS EPIDEMICS

Adequacy by Population



Montana Population



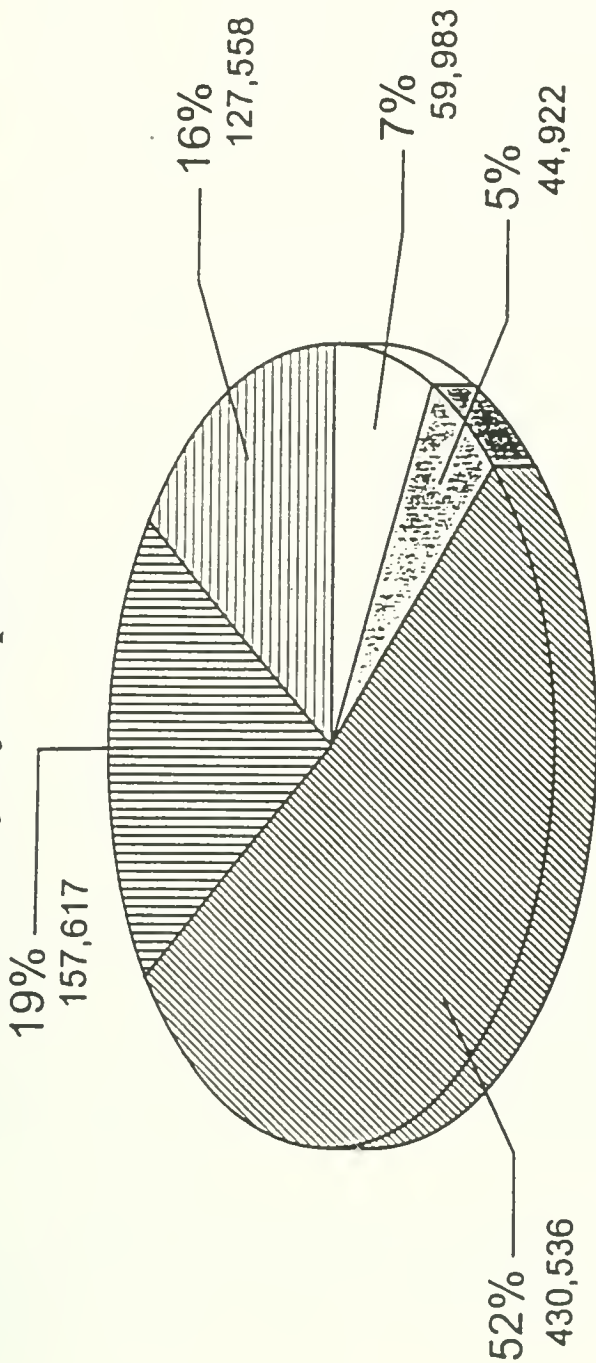
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Examples: Notifying contacts of a communicable disease; managing a measles outbreak, providing and tracking immunizations.

The capacity to prevent epidemics was viewed as the strongest core function with the majority, 79%, of Montana's residents living in an area where the adequacy of this function was rated as half adequate (50% adequacy) or greater with 26% of these being in the top (strongest) quartile.

ENVIRONMENTAL PROTECTION

Adequacy by Population



Montana Population



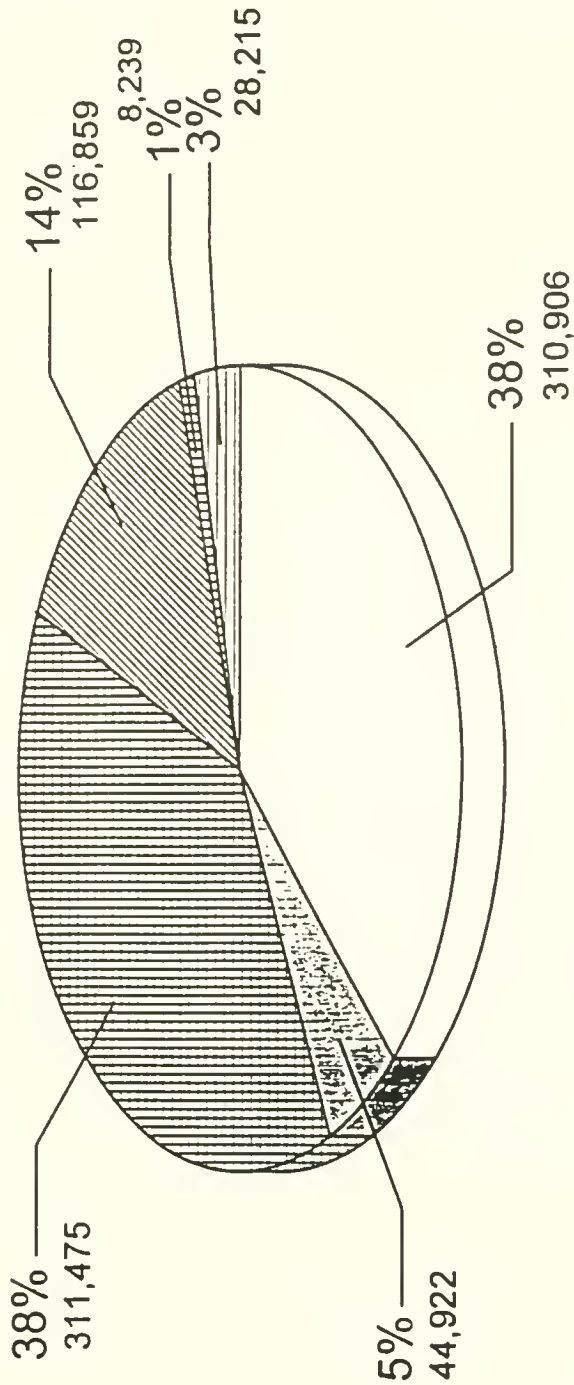
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Examples: Sewer and food service inspections, water testing, lead poisoning prevention, solid and hazardous waste programs, air quality programs.

52% of Montanan's live in an area in which the adequacy of environmental protection was rated to be half (50%) or greater up to three-quarters adequate with no ratings reported in the top quartile.

RESPONDS TO DISASTER

Adequacy by Population



Montana Population



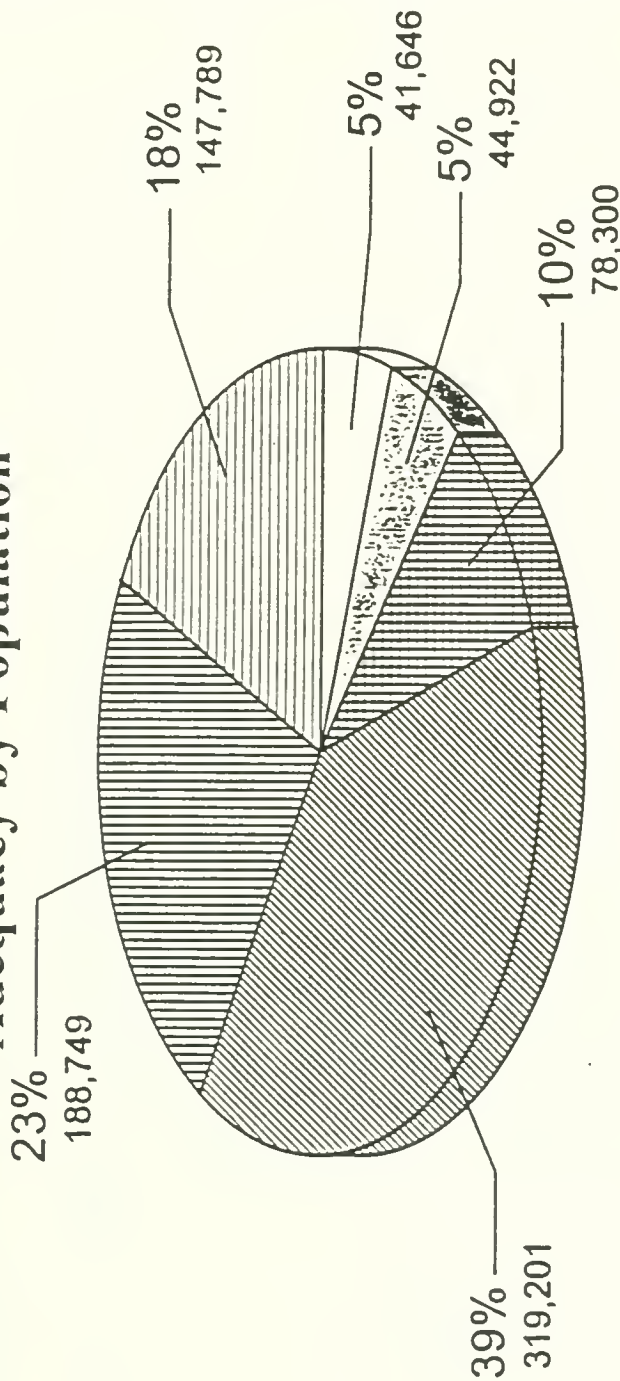
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Examples: Having a community disaster plan in place.

52% of people live in an area in which the ability to respond to disasters is rated at half adequate or greater with 38% in the top quartile and 14% in the third quartile. However, 38% of the population lives in an area in which the adequacy was rated as "unknown."

NURSING SERVICES

Adequacy by Population



Montana Population



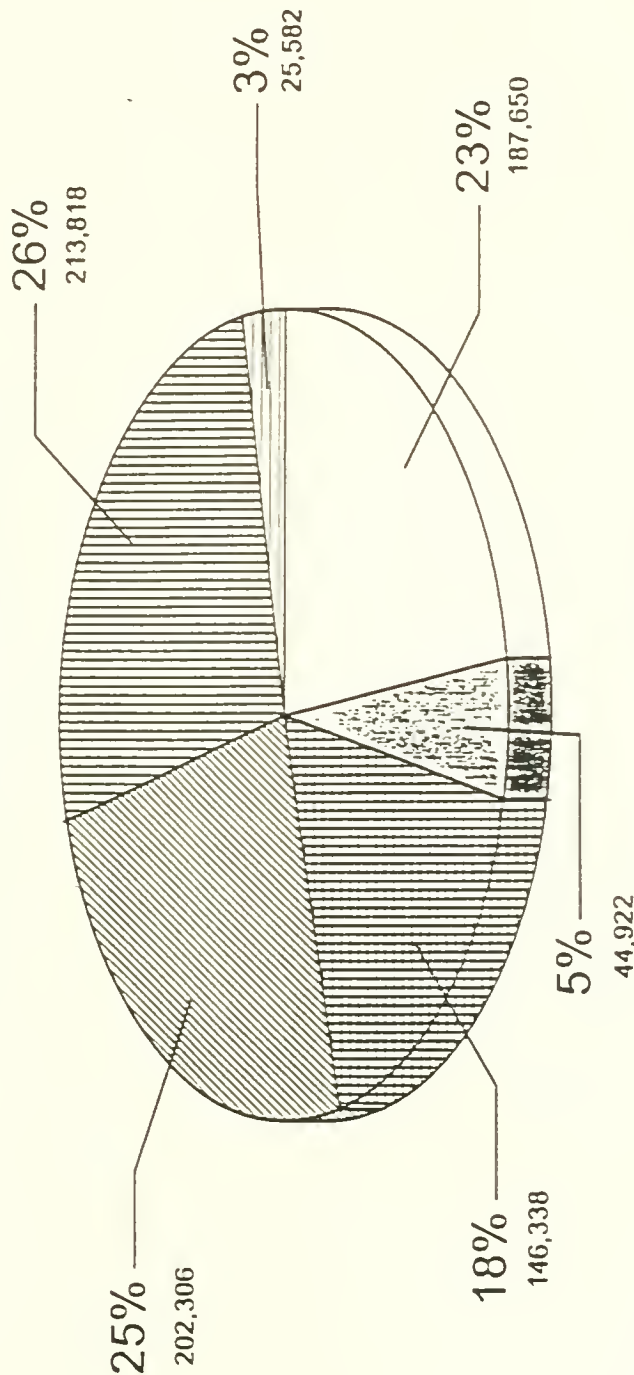
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Examples: Home visiting and educating pregnant women and young families; school nursing; home health; occupational health nursing.

49% of Montanan's live in an area in which the adequacy of public health nursing services is rated to be at least half, yet another 41% of responses fell at less than half.

MOBILIZES COMMUNITY

Adequacy by Population



Montana Population



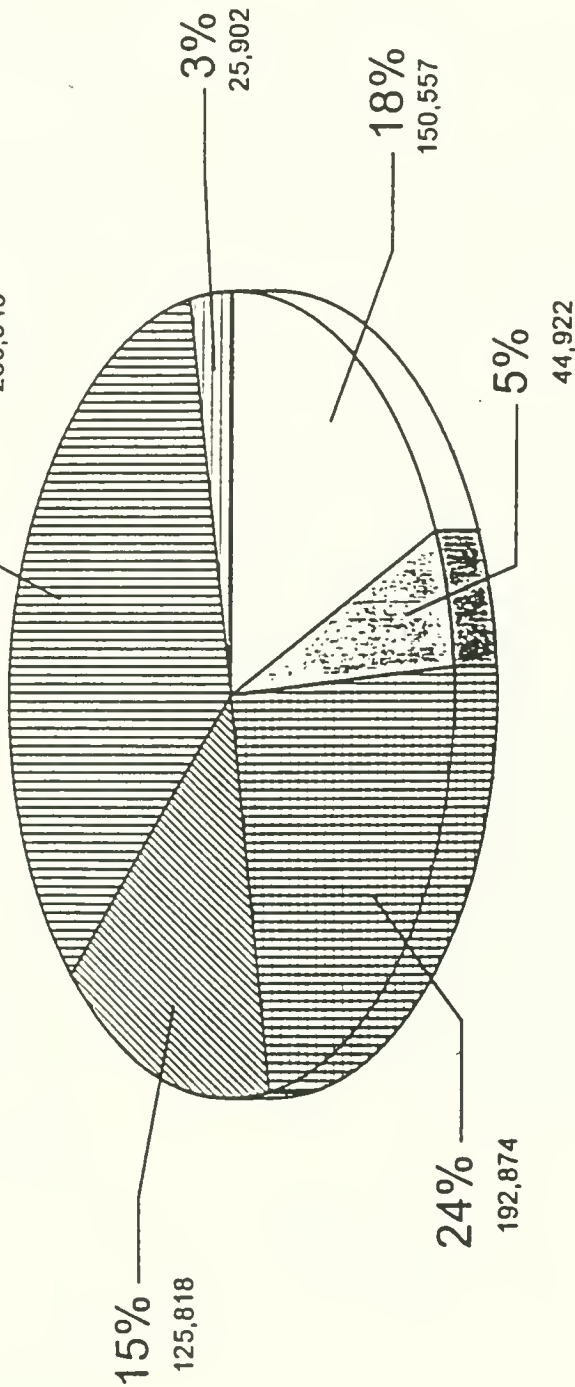
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Examples: Bringing together community resources to respond to its unique public health problems such as developing a program to reduce low birthweight babies or to improve air quality.

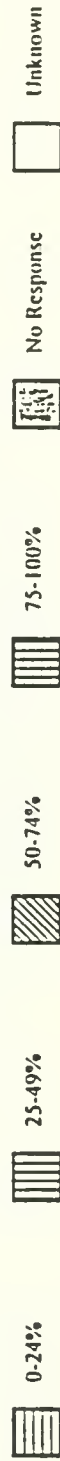
This function ranged widely with 43% of people reportedly covered at a level of half adequate or greater and another 52% in an area in which adequacy is rated less than half (29%) or unknown (23%).

DEVELOPS HEALTH-BASED POLICY

Adequacy by Population



Montana Population



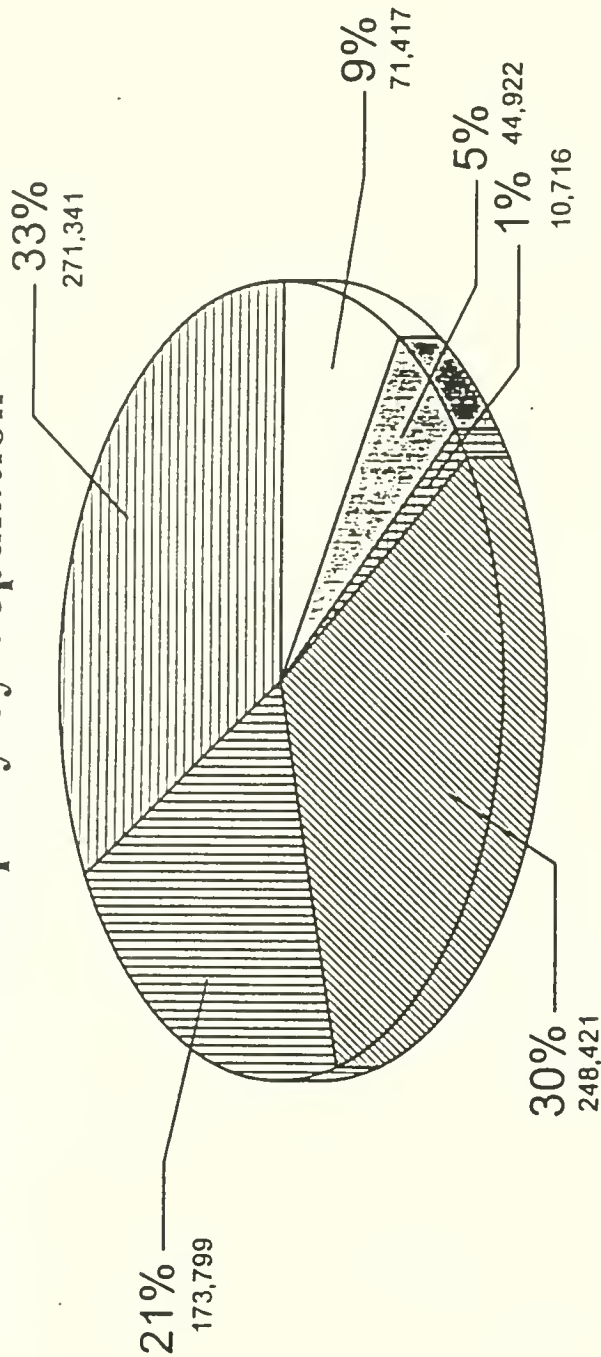
Examples: Based on assessment of health status and related conditions, developing and regularly reviewing community-based policies such as adopting standards for immunization practices sewer policies to protect water quality

This function straddles the half adequate demarcation with 39% of Montanans living in an area where this core public health function is estimated to be at least half adequate, including 24% of these in the strongest quartile; yet another 37% of responses fell at less than half adequate and 18% as unknown.

C: 06

PROMOTES HEALTHY BEHAVIORS

Adequacy by Population



Montana Population



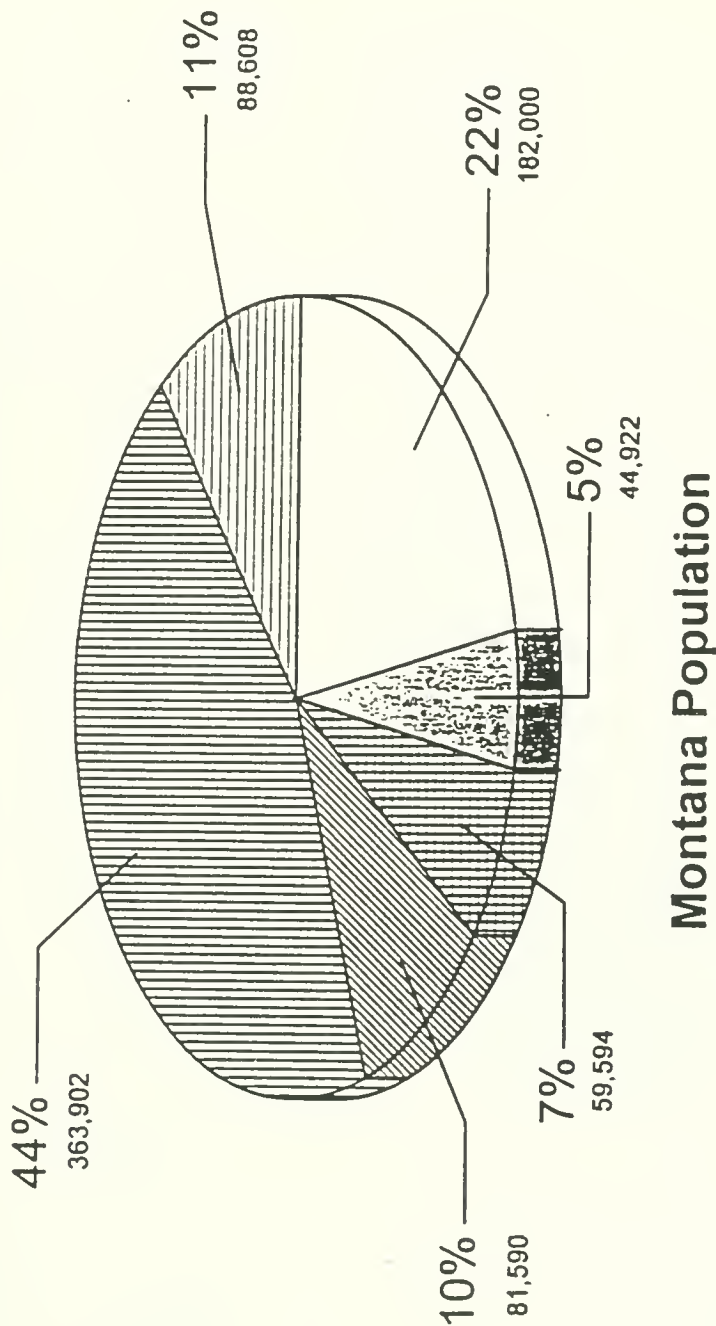
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Examples: Initiating a community-based seat belt promotion program or a healthy heart campaign.

This function was rated as particularly weak, with 54% of Montana's population living in an area where the ability to promote healthy behaviors was estimated to be less than half adequate.

MONITORING HEALTH STATUS

Adequacy by Population



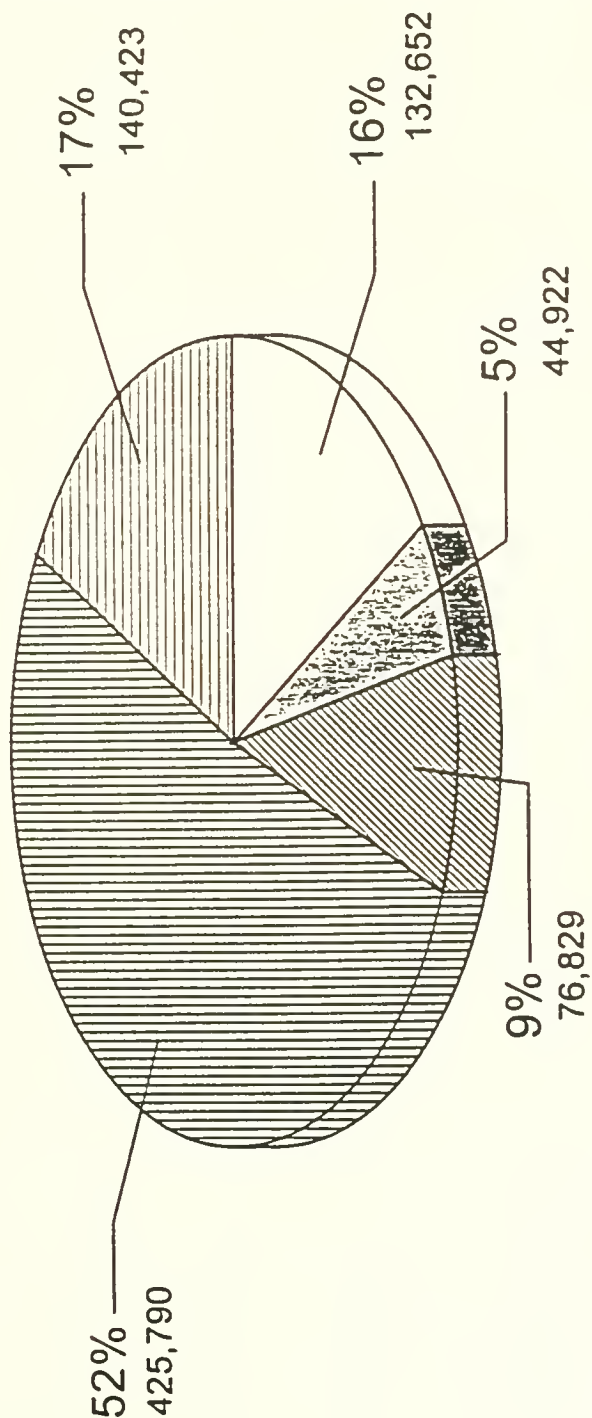
Examples: Regularly profiling and analyzing, trends in disease, injury, deaths, and contributing factors; compiled locally or regionally in relation to state and national data and the DHHS health status goals, "Healthy People 2000".

This core function was rated particularly weak with 55% of the population living in an area in which the ability to monitor health status was reported as less than half adequate; and a large proportion (22%) living in an area in which the adequacy of this core function was reported as unknown.

C: 05

PROVIDES SERVICES FOR UNDERSERVED

Adequacy by Population



Montana Population



C: 09

Examples: Community health centers, sliding scale family planning clinics, social services, interpreter services, transportation.

69% of Montana's population lives in an area in which the adequacy of providing services to the underserved is rated as less than half.

AVERAGE PERCENT ADEQUACY FOR ALL PUBLIC HEALTH FUNCTIONS



REGION 1

Population = 96,915 (12% of State Population)

	0-24%	25-49%	50-74%	75-100%
1. Prevents Epidemics	X	X		
2. Promotes Healthy Behaviors				
3. Nursing Services		X		
4. Environmental Protection	X			
5. Monitoring Health Status		X		
6. Develops Health-Based Policy		X		
7. Mobilizes Community			X	
8. Responds to Disaster			X	
9. Provides Services for Underserved	X			

AVERAGE PERCENT ADEQUACY FOR ALL PUBLIC HEALTH FUNCTIONS

REGION 2



Population = 139,600 (17% of State Population)

	0-24%	25-49%	50-74%	75-100%
1. Prevents Epidemics	X			
2. Promotes Healthy Behaviors	X			
3. Nursing Services	X			
4. Environmental Protection	X			
5. Monitoring Health Status		X		
6. Develops Health-Based Policy	X			
7. Mobilizes Community		X		
8. Responds to Disaster			X	
9. Provides Services for Underserved	X			

AVERAGE PERCENT ADEQUACY FOR ALL PUBLIC HEALTH FUNCTIONS



REGION 3

Population = 158,137 (19% of State Population)

	0-24%	25-49%	50-74%	75-100%
1. Prevents Epidemics	X			
2. Promotes Healthy Behaviors	X	X		
3. Nursing Services		X		
4. Environmental Protection		X		
5. Monitoring Health Status	X			
6. Develops Health-Based Policy		X		
7. Mobilizes Community	X			
8. Responds to Disaster			X	
9. Provides Services for Underserved	X			

AVERAGE PERCENT ADEQUACY FOR ALL PUBLIC HEALTH FUNCTIONS



REGION 4

Population = 202,448 (25% of State Population)

	0-24%	25-49%	50-74%	75-100%
1. Prevents Epidemics		X		
2. Promotes Healthy Behaviors	X	X		
3. Nursing Services		X		
4. Environmental Protection		X		
5. Monitoring Health Status		X		
6. Develops Health-Based Policy			X	
7. Mobilizes Community			X	
8. Responds to Disaster			X	
9. Provides Services for Underserved	X	X		

AVERAGE PERCENT ADEQUACY FOR ALL PUBLIC HEALTH FUNCTIONS

REGION 5



Population = 223,516 (27% of State Population)

	0-24%	25-49%	50-74%	75-100%
1. Prevents Epidemics	X	X		
2. Promotes Healthy Behaviors				
3. Nursing Services		X		
4. Environmental Protection		X		
5. Monitoring Health Status		X		
6. Develops Health-Based Policy		X		
7. Mobilizes Community		X		
8. Responds to Disaster			X	
9. Provides Services for Underserved	X	X		

THE PROPOSAL

The argument for strengthening public health to complement health care reform is compelling. In light of the status report on Montana's public health system, the argument takes on urgency. We must build upon our public health infrastructure in a planned, measurable fashion using health status as the blueprint.

Building a Health Status Data Base and Planning Capability

The most telling measure of public health's adequacy would be a measure of the public's health, itself. For policy and planning purposes, a comprehensive, specific, and longitudinal look at health status in accordance with DHHS's national health status goals, "Healthy People 2000" is essential. Federal grant monies are becoming increasingly tied to individual states' abilities to plan and evaluate progress in accordance with these guidelines.

Montana can not quite produce this measure, yet. A great deal of data exists, but there are holes in the data base and there is no system for compiling the data in accordance with the national goals or in a way usable for local planning. MDHES has listed, as its first legislative priority for the upcoming session, a budget request to build the health status data base. To make the data base usable at the local or regional level, additional funds are proposed herein.

The health profiles recently produced by Missoula and Lewis and Clark Counties have already had far-reaching effects in identifying local public health issues and stimulating home-grown responses. Public health simply cannot carry out its main function of assessment without such a tool. DHHS Year 2000 goals call for states to develop the capacity to conduct "periodic analysis and publication of data needed to measure progress toward objectives."

At present, most counties report not having adequate capacity to perform this core function. Support of this proposal would build this capacity by assisting individual counties, groups of counties, or regions technically and financially to:

- 1) mobilize a local or regional coalition to conduct health monitoring and planning;
- 2) complete a local health status profile;
- 3) prepare a community-based action plan to identify and address public health priorities;
- 4) integrate with state data base use and planning; and
- 5) evaluate progress in implementing plan, effect of health policy, and health resource expenditures.

Counties or regions could apply for funds for five regional start-up projects. These demonstration projects will help determine the scope, shape, and cost of building this core function throughout the state over time.

Strengthening Montana's Public Health Infrastructure

With health status for a map, a reliable public health infrastructure can serve as the vehicle to improve public health. An objective measure of Montana's public health machinery and its capacity is in order. Here again, however, is a basic need unmet. It is simply not possible to conduct the objective evaluation of a system, that is necessary to plan for that system, in the absence of standards. Montana's schools, daycares, hospitals, laboratories, all have standards. How striking that public health does not.

Counties or regions, for the most part, do not have capacity standards to serve as goals, let alone guarantees that a communicable disease report will be thoroughly tracked; public health nurses will be available to families at risk; environmental hazards will be identified or addressed; or that the health of the population will be monitored or addressed, for example. Proposed is a process similar to one undertaken in Washington state that allows Montanans to set their own standards for public health, and to do so in a fashion that builds upon, rather than overburdens, our already fragile infrastructure; as follows:

The Department of Health and Environmental Sciences shall adopt a "Public Health Improvement Plan" developed by a specially appointed task force comprised of representatives of local health departments and public health professionals, area Indian health services, health services providers, legislators, and a Health Care Authority liaison and citizen concerned about public health. The plan shall provide an accounting of strengths and deficits in our public health system at the state and local level and determine a plan for maintaining strengths and addressing deficits. The "Public Health Improvement Task Force" shall be:

- (I) Chaired by the Director of the State Department of Health and Environmental Sciences (MDHES) and comprised of the following members:
 - (a) Four public health representatives from the state's largest health departments; with one having expertise in maternal-child health issues or health promotion; one having expertise in environmental health; and two serving as County Health Officer or Department Director; and
 - (b) Two public health representatives from the public health departments or programs in the state's frontier counties with populations over 5,000; and
 - (c) One public health representatives serving in a county with less than 5,000 residents; and
 - (d) One representative of Indian Health Services; and,
 - (e) One member of the Montana House of Representatives;
 - (f) One member of the Montana Senate; and
 - (g) One health services provider; and
 - (h) One citizen concerned with public health; and
 - (i) One member of the Montana Health Care Authority serving as liaison; and

(j) One staff member of MDHES.

(II) Appointed by the Governor by June 30, 1995 and report to the Legislature by September 30, 1996.

(III) Staffed by the Department of Health and Environmental Sciences with additional funds provided by the Legislature for contracted services, expenses for operating costs, expense reimbursement for task force members for travel, communications, per diem, and lodging, and contracted services costs for plan preparation.

The Public Health Improvement Plan shall include:

- (I) Definition of capacity standards for public health protection through the core functions of assessment, policy development, and assurances;
 - (a) Accounting of communities not meeting capacity standards or of core functions not being adequately provided statewide;
 - (b) Accounting of communities or statewide core functions strengths;
 - (c) A budget and staffing plan for bringing all communities to capacity standards;
 - (d) An analysis of the costs and benefits expected from adopting capacity health standards;
- (II) Recommended strategies and a schedule for improving public health programs at the state and local level, including:
 - (a) A delineation of urgent core function needs across the state or in certain geographical areas; and
 - (b) An examination of the feasibility of regionalization or other form of cost-effective administration and service delivery; and,
 - (c) Identification of methods to network local public health services across the state to each other and to state services; and,
 - (d) Review of laws, regulations, and policies pertaining to public health;
- (III) Consideration of specific population-based activities including health data assessment chronic and infectious disease surveillance; rapid response to outbreaks of communicable disease; efforts to prevent and control specific communicable diseases, such as tuberculosis and acquired immune deficiency syndrome; health education to promote healthy behaviors and to reduce the prevalence of chronic disease, such as those linked to the use of tobacco; access to primary care in coordination with existing community and migrant health clinics and other not for profit community-based health care organizations; programs to ensure children are

born as healthy as possible and they receive immunizations and adequate nutrition; efforts to prevent injury; programs to ensure the safety of drinking water and food supplies; poison control; trauma services; and other activities that have the potential to improve the health of the population or special populations and reduce the need for or cost of health services.

(IV) A funding plan including:

- (a) A recommended level of funding for public health services to be expressed in terms of a percentage of total health service expenditures in the state or a set per capita amount, and;
- (b) Methods to ensure that such funding does not supplant existing funds; and,
- (c) Identification of federal and private funding opportunities;

(V) Identification of methods for integrating health status data in the planning process; and in conjunction with local or regional planning;

(VI) Recommendations for coordinating public health improvements with health care reform efforts and for continuance of the task force beyond 1999; and,

(VII) A specific implementation plan for the period from 1997 to 1999.

SUMMARY AND REQUEST

The Montana Health Care Authority has the daunting charge to reform our health care system -- to balance the seemingly opposite forces of improving access, yet controlling costs. No plan, no matter how well conceived, however, can achieve this end without the support of a strong public health system to improve health status, seize opportunities for prevention, and lessen the demand on our health care system. The exponential gains of investing in public health are well proven and the professionals serving in Montana's public health system very much wish to support the health care reform effort. A position of mutual support, however, is needed. Just as the medical system is overburdened, so is the public health system, and neither can fully carry out its unique role should the other fail.

For its part, Montana's Committee for Improving Public Health proposes starting a process to examine, standardize, and strengthen public health. It is a process that is fixed on the ultimate point of the health care debate -- improving the health status of Montana's citizens. We respectfully request that the Authority forward this proposal to the legislature with a strong recommendation for its passage.

BUDGET

For the Period June 30, 1995 through September 30, 1996

CONTRACTED SERVICES

Coordinator	
Full-time x 15 months (2600 hours) @ \$15.00/hr.	\$39,000
Clerical Support	
Full-time x 15 months (2600 hours) @ \$ 9.00/hr.	23,400
Research Consulting Services	25,000
Capacity Standards Actuarial Study	
Contractors Travel	18,810
2 people, 4 trips/month, averaging 400 miles ea. @\$15.50 per diem, \$31.25 lodging., \$0.275/mi.	
Subcontracts to Regions for Data Base Demos	60,000
5 projects @ \$12,000 ea.	
Subtotal	\$166,210

OPERATIONS

Task Force Travel	35,270
15 people, 1 trip/mo., avg. 400 mi. ea., @\$15,50 per diem, \$31,25 lodging, \$0.275/mile	
Basic Phone	1,000
Long Distance Phone	2,500
Postage	7,500
Printing	5,000
Met Net (State Video Conference)	2,400
Subtotal	\$ 53,670

<u>TOTAL REQUEST</u>	<u>\$219,880</u>
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Montana's Committee for Improving Public Health

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Polson

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Cascade Health Department
Region II Vice-President
Montana Public Health Assc.

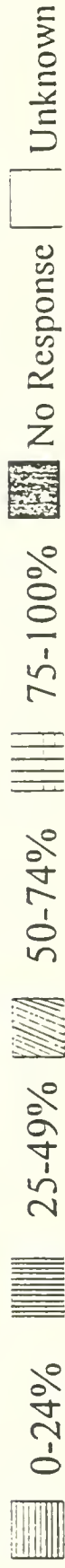
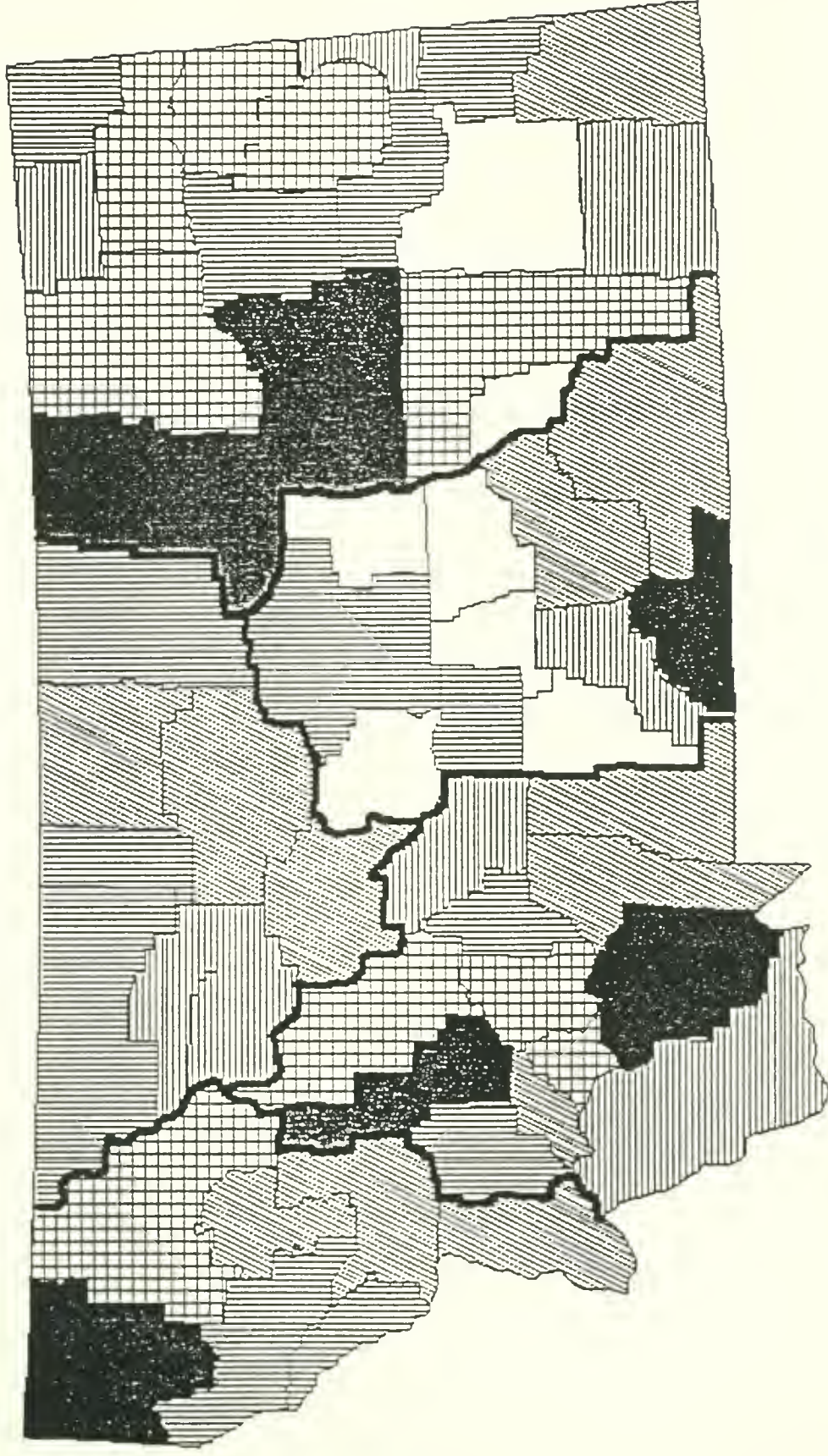
APPENDICES
to
Public Health Improvement Plan

Survey Results by County

Survey Tool

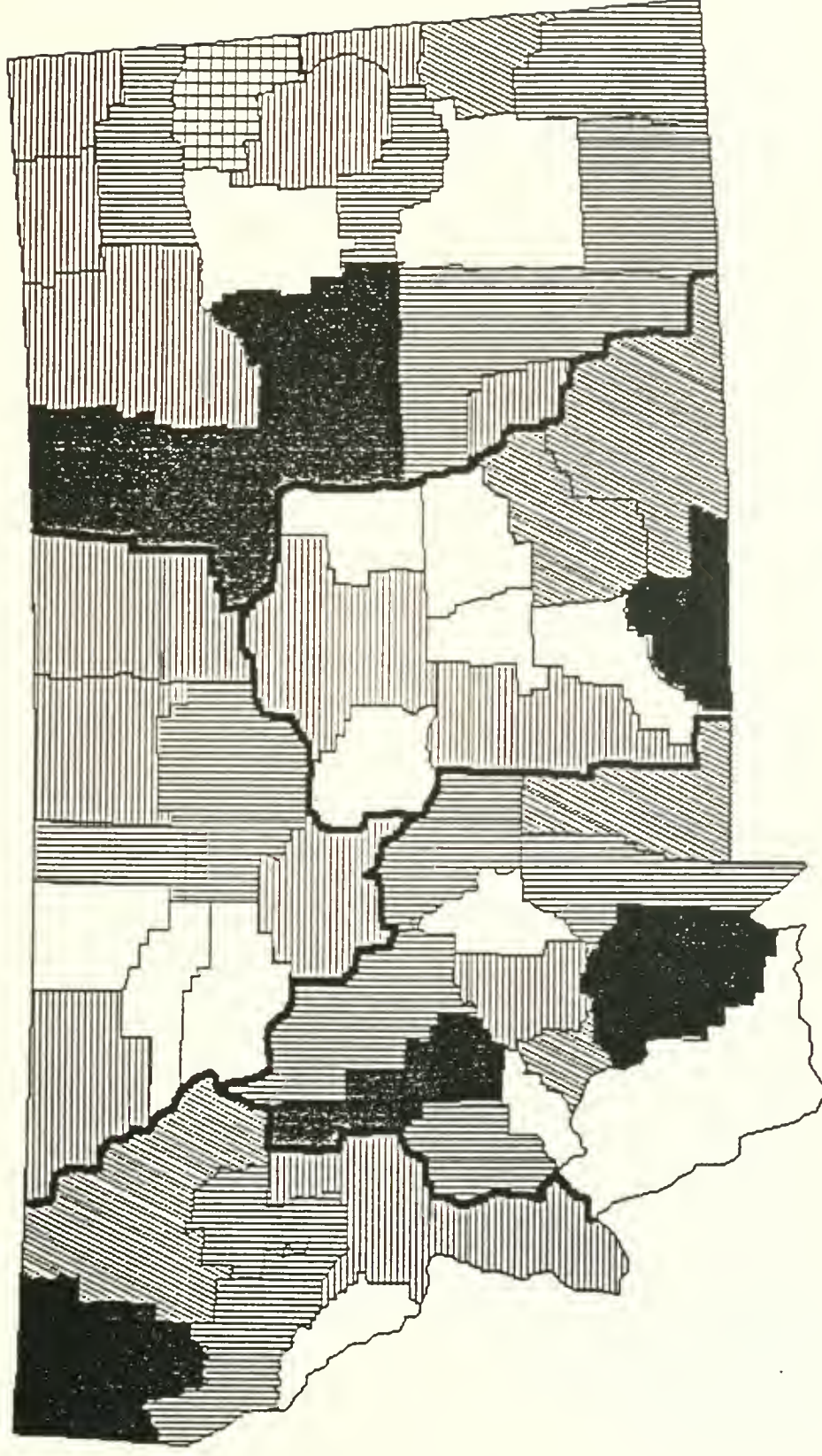
PREVENTS EPIDEMICS

Adequacy by County



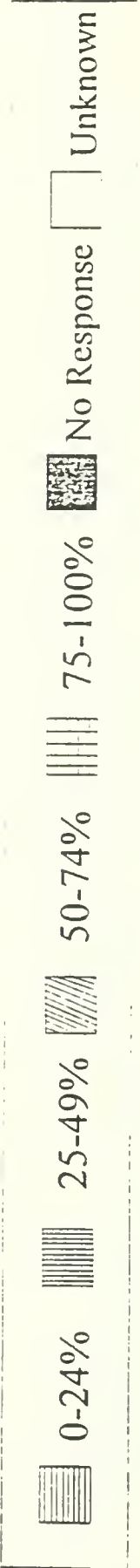
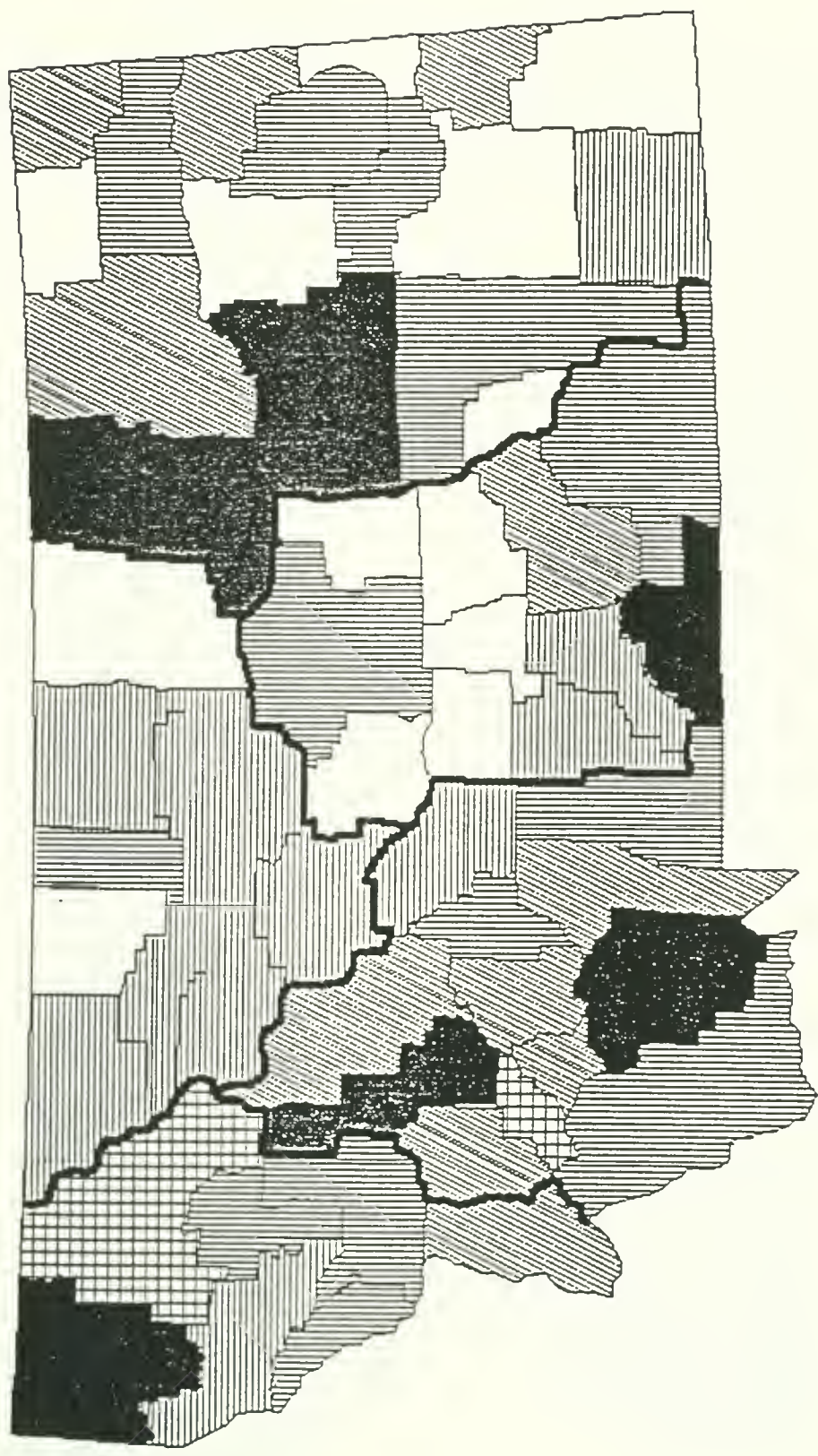
PROMOTES HEALTHY BEHAVIORS

Adequacy by County



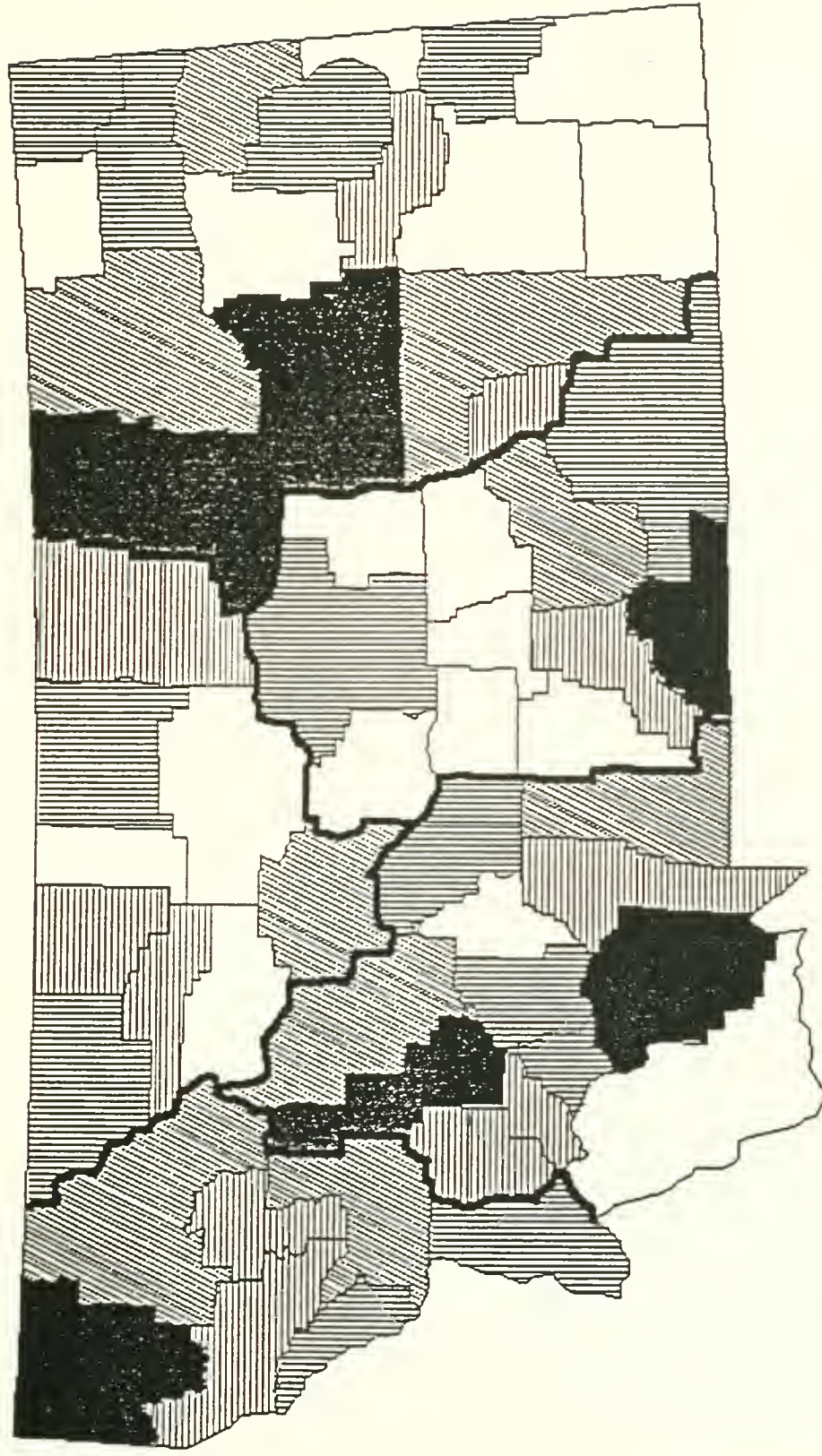
NURSING SERVICES

Adequacy by County



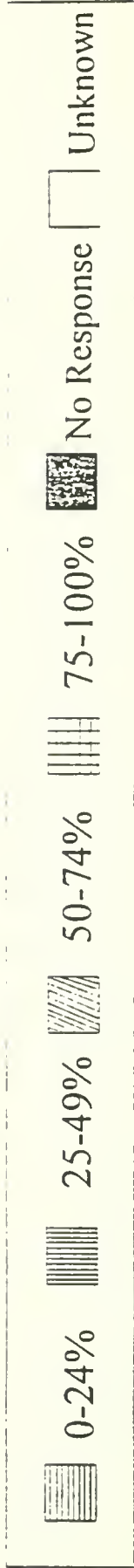
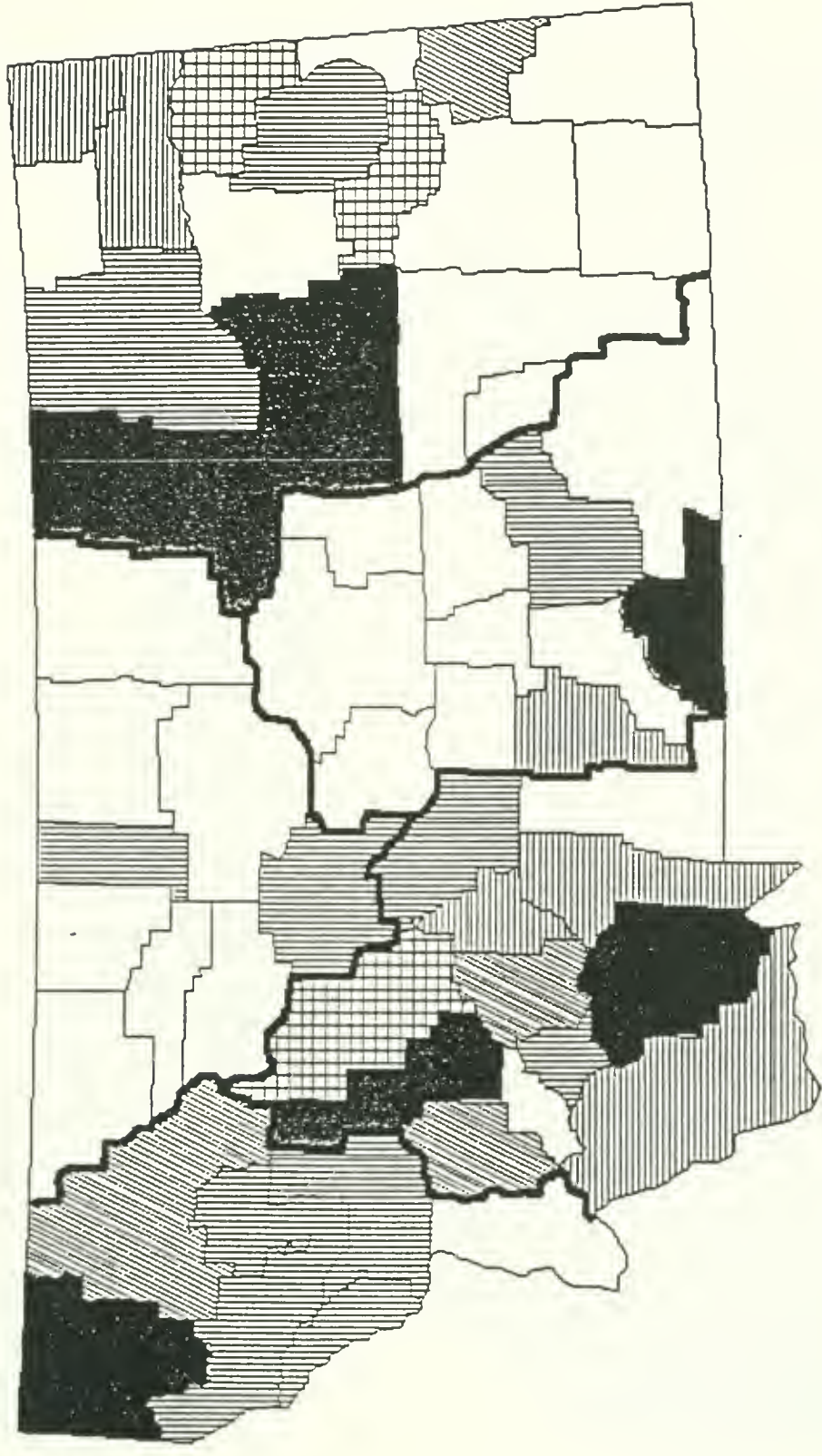
ENVIRONMENTAL PROTECTION

Adequacy by County



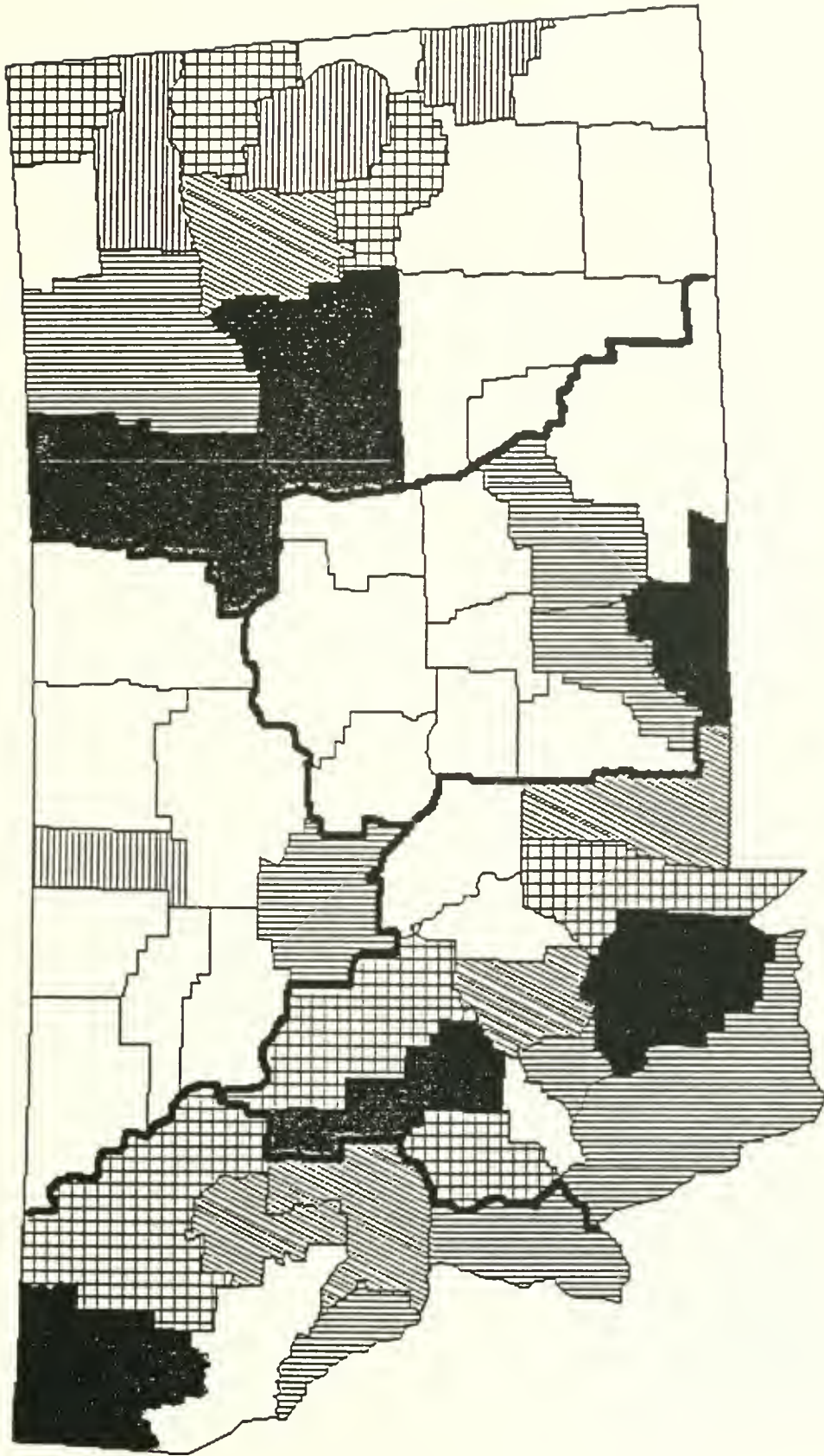
MONITORING HEALTH STATUS

Adequacy by County



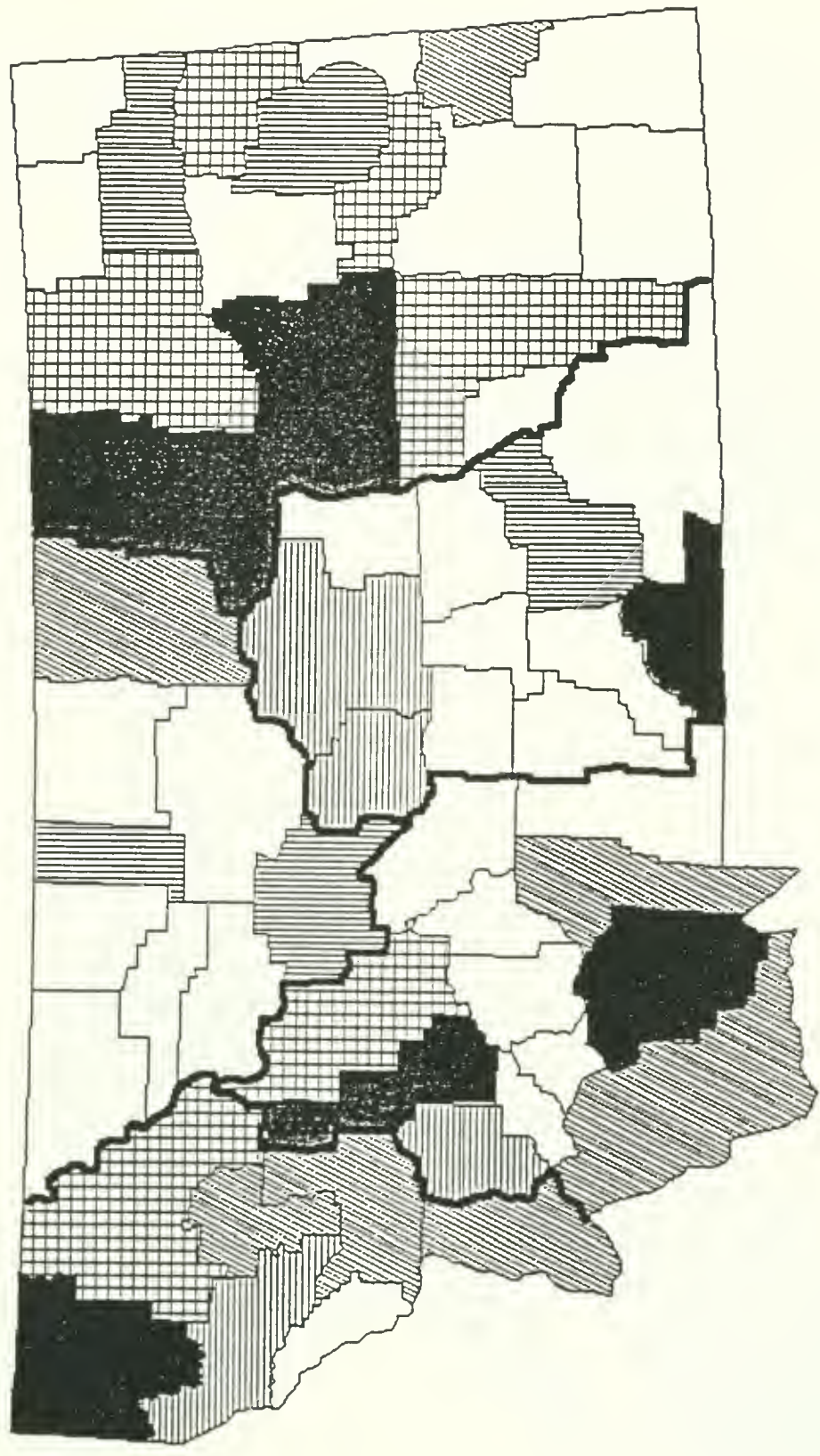
DEVELOPS HEALTH-BASED POLICY

Adequacy by County



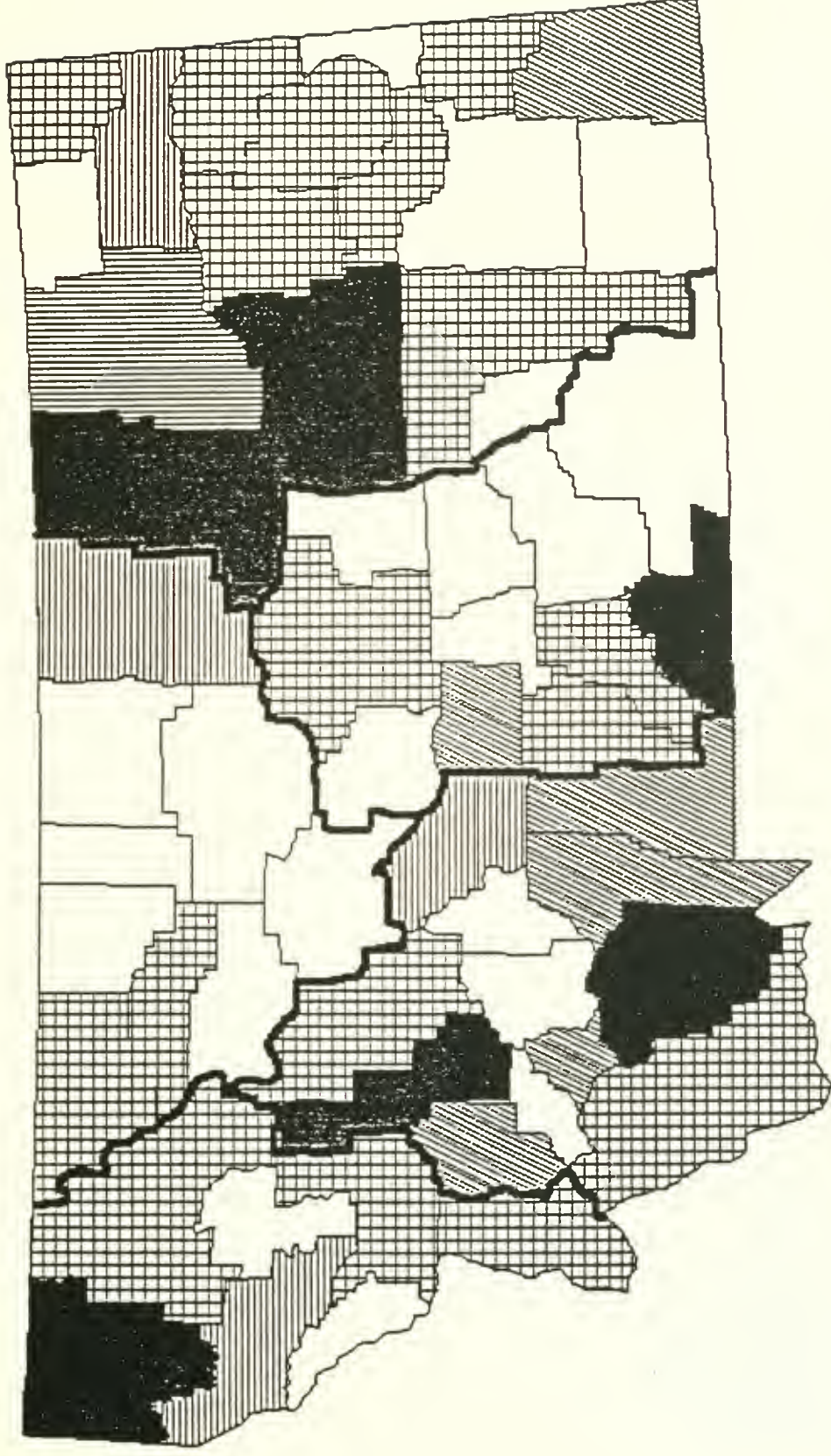
MOBILIZES COMMUNITY

Adequacy by County



RESPONDS TO DISASTER

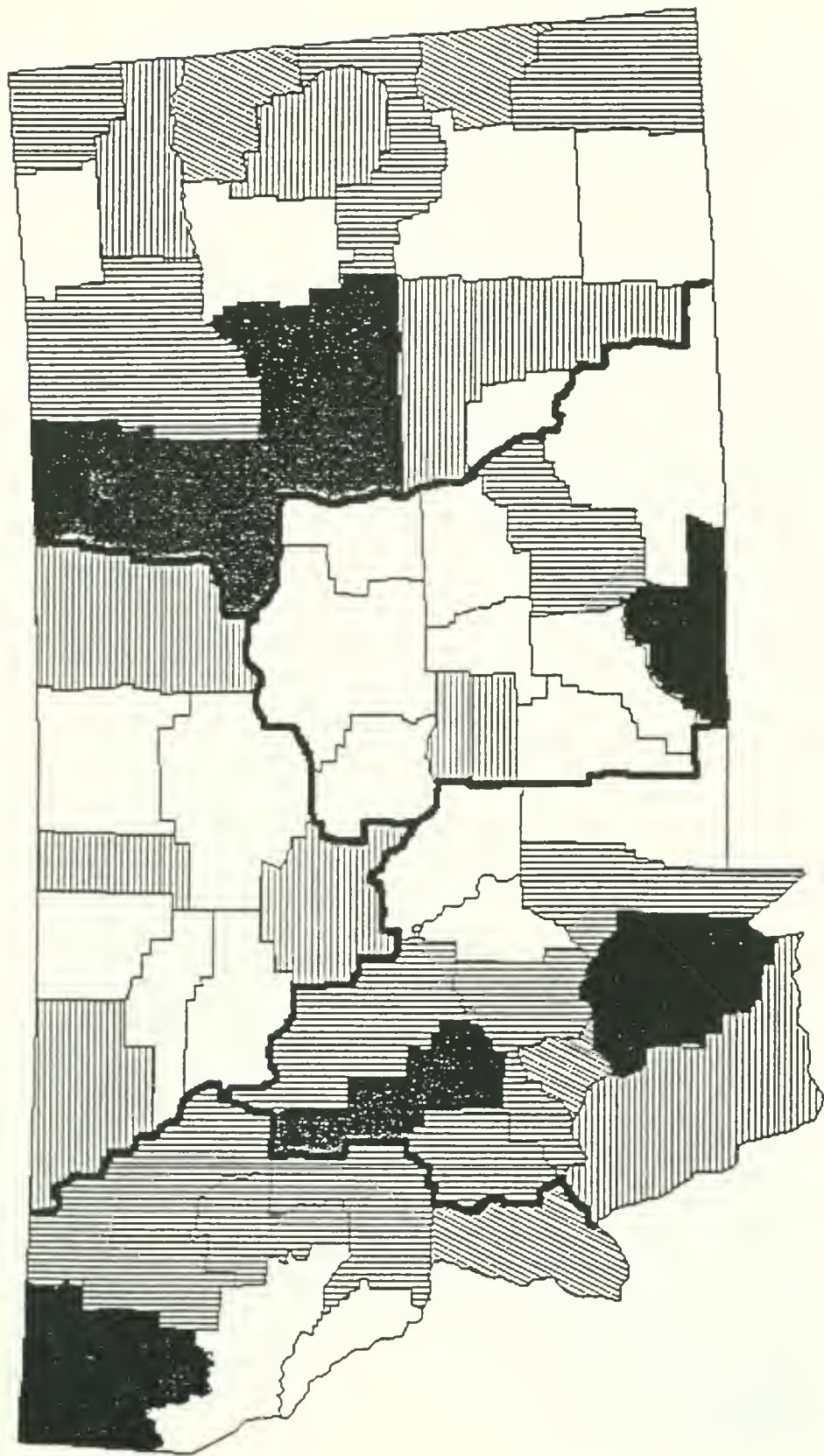
Adequacy by County



0-24% 25-49% 50-74% 75-100% No Response Unknown

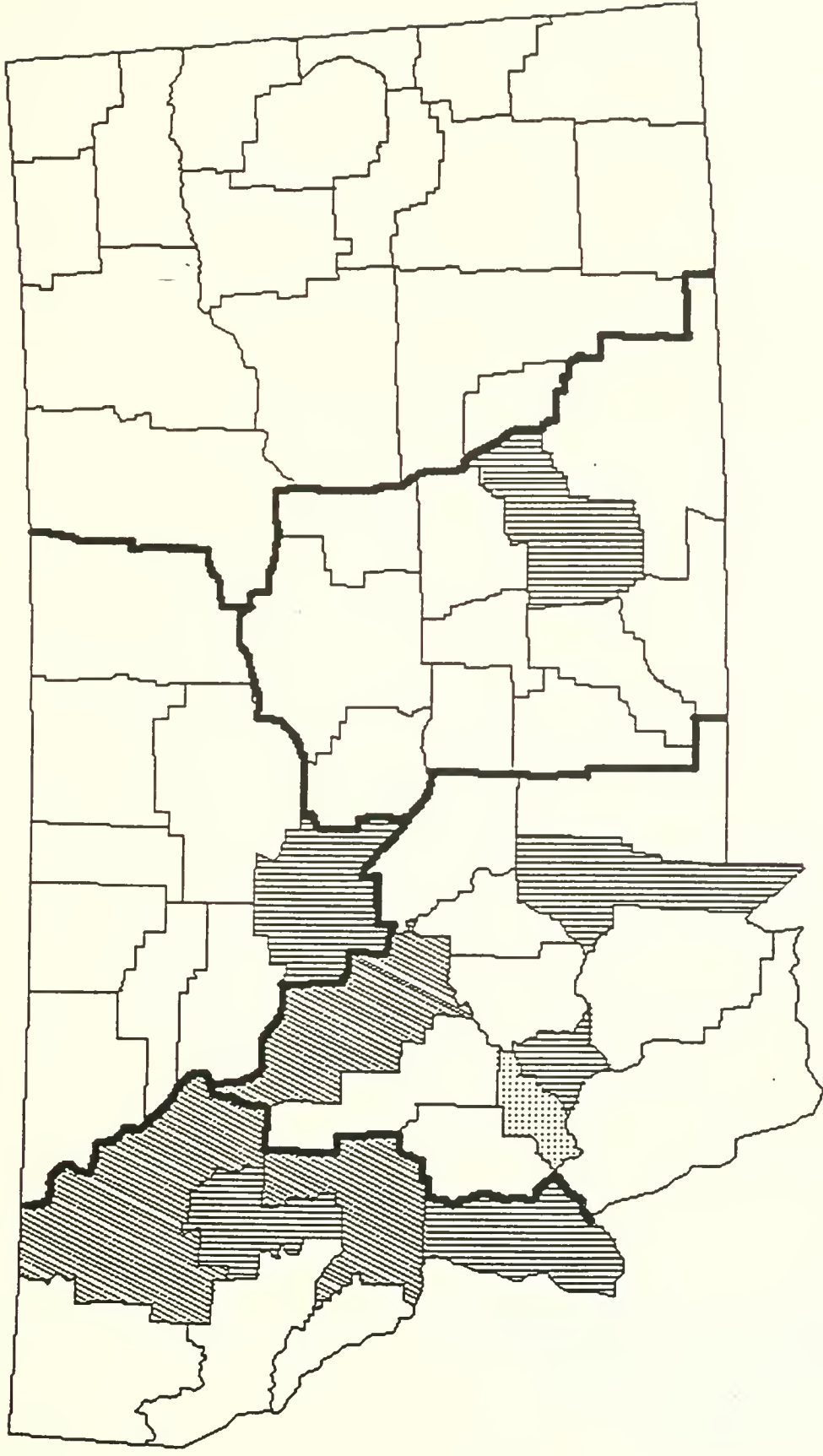
PROVIDES SERVICES FOR UNDERSERVED

Adequacy by County



0-24% 25-49% 50-74% 75-100% No Response Unknown

AVERAGE OF ALL PUBLIC HEALTH FUNCTIONS FOR THE TOP 10 COUNTIES



[illegible]

Less than 50% Adequacy in All Public Health Functions

No Response

SURVEY OF LOCAL CORE PUBLIC HEALTH FUNCTIONS

COUNTY: _____

POPULATION: _____

RESPONDENT: _____

TITLE: _____

ADDRESS: _____

PHONE: _____

TOTAL EMPLOYEES IN PUBLIC HEALTH IN YOUR COUNTY: _____

TOTAL CURRENT YEAR PUBLIC HEALTH BUDGET: \$ _____

PLEASE READ ENCLOSED DIRECTIONS BEFORE COMPLETING

IF QUESTIONS, PLEASE CALL ELLEN LEAHY AT 523-4770

 PLEASE RETURN COMPLETED SURVEY BY JUNE 3 TO:

(Stamped envelope provided)

Lorena Hillis
Missoula City-County Health Department
301 West Alder
Missoula, MT 59802

OR FAX TO 523-4781

THANK YOU FOR TAKING THE TIME TO HELP WITH THIS SURVEY

1 Adequacy

☐ 0-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ unknown

PREVENTS EPIDEMICS

Responds to reports of communicable disease; notifies contacts and follows-up

Conducts surveillance of reportable diseases to identify apparent outbreaks, clusters, trends. (Such as foodborne outbreaks, cancer clusters, trends in measles or TB)

Conducts epidemiologic investigations and intervenes with outbreaks, clusters or rising trends of communicable disease.

Promotes immunization rate through:

Public immunization clinics

Immunization outreach efforts

Special focus on 0 to 2 year-olds

Identifies and controls communicable disease through public health clinical services:

TB testing

☐ 0-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ Unknown

TB Compliance follow-up and directly observed TB prophylaxis

□ □ □ □ □

STD diagnosis and treatment

STD diagnosis and treatment

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV counseling and testing (Indicate if free, anonymous)							

HIV counseling and testing (Indicate if free, anonymous)

<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Early intervention program or referral for HIV +
---	---	--

Early intervention program or referral for HIV +

PROMOTES HEALTHY BEHAVIORS

Conducts population-based approaches to improving nutrition:

☐☐☐ ☐☐☐ Women Infants and Children (WIC) special nutrition program

Women Infants and Children (WIC) special nutrition program

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Population-wide nutrition education programs (focused on prevention of cancer, heart disease, obesity, malnutrition) Please list what is in place in your county.

Conducts population-based public health education programs to:

Prevent Injury:

[illegible]

Present

Do not know

Yes

No

Do not know

Adequacy

0-24

25-49

50-74

75-100

Unknown

Drinking and driving prevention program (Indicate if youth/adult focus)

Workplace injury prevention program

Other: _____

Prevent substance abuse and addiction:

Alcohol and other drugs prevention program (Indicate if youth/adult focus)

Tobacco use prevention program (Indicate if youth/adult focus)

Prevent chronic disease:

Cancer prevention program (e.g. breast, lung, prostate, colorectal, skin) List specific programs underway in your county. (Indicate youth/adult focus)

Cardiovascular disease prevention program (e.g. public education, cholesterol and blood pressure screening, healthy lifestyles initiatives) List efforts underway in your county. (Indicate youth/adult focus)

☐ Yes
☐ No
☐ Do not know

☐ 0-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ Unknown

HIV health education and risk reduction (HERR) program (Indicate if youth/adult focus)

Population-based health promotion among children:

School-based K-12 health education curriculum

Fluoride program in schools (unless fluoridated water)

PROVIDES PUBLIC HEALTH NURSING SERVICES

Prevents health problems among populations at-risk:

Home visiting and support services to pregnant and newly-delivered high-risk women (e.g. women with social, medical, or other risks including pregnant teens.)

Home visiting and support services to families at risk (e.g. social or health risks, childrearing problems, abuse and neglect or risk of, children with special health needs)

ent .
☐ Yes
☐ No
☐ Do not know

☐ 0-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ Unknown

Home health nursing services to provide skilled physical care in the home to disabled, elderly, rehabilitating, dying, or special needs clients, including infants

Promotes health of population at-large:

School nursing program K-12

PROTECTS THE ENVIRONMENT, FOOD, WATER AND HOUSING

Protects drinking water supplies:

[illegible]

☐ Yes
☐ No
☐ Do not know

Specific program to protect local water supply (e.g. water quality district, wellhead protection, monitoring surface water quality) (Please identify any such effort.)

Protects against hazards in the environment:

□□□□□□□□ Restaurant inspections and other food and consumer and safety services

Septic inspections and permitting program

<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/>

Response to spills including sewage and toxic chemicals

[illegible][illegible]

Protects air quality:

Outdoor:

Particulate monitoring and control (Indicate if not necessary)

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>

Carbon monoxide monitoring and control (Indicate if not necessary)

Present Adequacy

☐ Yes
☐ No
☐ Do not know

☐ 0-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ Unknown

Other: _____

Indoor:
 Smoke-free environment promotion

Radon testing promotion

MONITORS HEALTH STATUS OF THE POPULATION AND RESOURCES

Comprehensively assesses the health of the local population in accordance with Healthy People 2000 goals.

Identifies populations at risk for particular diseases and conditions such as tuberculosis, domestic violence, low-birthweight babies, chronic disease.

Assesses quality & accessibility of local health care services and facilities in relation to health care needs.

DEVELOPS HEALTH-BASED POLICY

Local health board, guided by assessment data and sound scientific process, meets regularly and sets local public health policy.

Present

☐ Yes
☐ No
☐ Do not know

<input type="checkbox"/>	0-24
<input type="checkbox"/>	25-49
<input type="checkbox"/>	50-74
<input type="checkbox"/>	75-100
<input type="checkbox"/>	Unknown

Board and/or staff advocate for public health in the local and state policy-making process.

[illegible]

MOBILIZES COMMUNITY FOR ACTION

Identifies public health problems and develops community coalitions to respond (such as, teen pregnancy, violence, hunger, use of alcohol and tobacco, environmental degradation, traffic injury.) List any recent or current examples of this core function in your county and comment on your county's ability to assess and respond to these types of public health issues.

RESPONDS TO DISASTER

[illegible]

PROVIDES ACCESS TO PERSONAL HEALTH SERVICES FOR SPECIAL NEEDS AND UNDERSERVED POPULATION

Please note that this section is to assess services (referral or direct care) aimed at the underserved. Therefore, please indicate any publicly-funded services available or special access agreements or efforts underway to help clients obtain private health services.

Present Adequacy

Yes ☐ No ☐ Do not know ☐

0-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ Unknown ☐

Primary care (If your county has a special referral program or direct care program such as a Community Health Center for the underserved, please identify it.)

Prenatal care (Indicate if you have a MIAMI program or satellite or other similar program in your county.)

Family planning (Indicate whether or not you have a Title X clinic accessible to the residents of your county)

Preventive care

Nutrition Counseling

Migrant health program (Indicate if not needed in your county)

Refugee health program (Indicate if not needed in your county)

Homeless health program (Indicate if not needed in your county)

Present

Adequacy

☐ Yes
☐ No
☐ Do not know

☐ 0-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ Unknown

Social work services

Dental, restorative and preventive

Mental health services (Indicate whether or not you have a Community Mental Health Center accessible to the residents of your county)

Alcohol and drug treatment services (Indicate whether or not you have a state-approved, accessible outpatient program in your county.)

Outreach, translators, transportation, daycare, and other special assistance as necessary for those with barriers to care.

COMMENTS

Please note any particular aspects of your county that pertain to public health or make comments necessary to completing this assessment of core public health functions in your county.

DIRECTIONS

ONE SURVEY PER COUNTY

1. Only one survey should be completed per county.

WHO SHOULD RESPOND

2. Whenever possible, someone working in a public health role should be the respondent. This person should possess the best knowledge of the local situation. It may be possible to convene a small group of public health employees to best complete the survey.

THE FIRST SET OF BOXES. "PRESENT"

3. Two responses are requested for each item. The first item entitled "Present" is to indicate whether or not a function or service is present in the county – *regardless of who provides it* – although most of the functions listed are unique to public health departments or employees.
4. If you answer "no" or "do not know" on the first item, meaning a function is not present or you are unable to determine if it is present, then a response in the second section of boxes is not needed.

THE SECOND SET OF BOXES. "ADEQUACY"

5. If you answer "yes" to the first item, meaning a function is present, then an assessment of its degree of "Adequacy" is requested. The adequacy of a function is dependent upon a number of factors, including but not limited to: capacity as related to program, budget, space, or staff ability to meet demand or conduct adequate outreach; quality; and accessibility related to client finances, location of services, other barriers.

EXAMPLES

Please rate adequacy to the best of your ability by taking all of these factors into consideration. For example:

- a. If your county WIC program only has enough slots available to serve 60% or the estimated eligible in our County, place an "x" in the box labeled "50 to 74% adequate.
- b. If your county sanitarian(s) are able to inspect at least 75% of licensed establishments every year, mark an "x" in the box labeled "75 to 100%" adequate.
- c. If 40% of the 0 to 2 year-olds in your county have had their immunizations on time, mark the "25 to 49%" box on that item.

- d. If you have not assessed your county health status in accordance with the Healthy People 2000 goals, mark "no" in the first "present" column and make no marks in the adequacy column. If however, you have assessed, for example, the goals related to one section of the entire document, such as infant mortality, mark the "1 to 24%" box.
- e. If your health board meets regularly but sets policy in a narrow arena of issues, assess the scope of their attention in relation to the more comprehensive scope of core functions and rate adequacy proportionately.

YOU ARE THE JUDGE

- 6. You or your team of responders know better than anyone the extent that public health reaches in your county. *Make your best estimate, exact figures are not needed.* And if you do not have enough information to even make an estimate, mark "unknown" in the "Adequacy" column.

COMMENTS

- 7. Write comments after each item as necessary to explain the situation in your county or the reason for your answer.

DISCLAIMERS

- 8. There will be some overlap in the survey that arises from the fact that individual counties arrange and entitle their services differently. Apologies if the format and wording used does not quite fit your county. Because core functions are by definition essential, there are *very few* functions that may not be needed in a particular area. If this is the case, indicate so in the comment area.
- 9. If you are the only or one of the few public health workers in your county, please do not feel overwhelmed by the comprehensive nature of the survey. It's purpose is to document what we do and do not have and to what degree. Please just do your best to respond and realize that documenting what we do not have is a first step in trying to attain it.

SHARE INFORMATION WITH REGIONAL HEALTH BOARD COUNTY REPRESENTATIVE

- 10. Enclosed is a list of the County Representatives to the Regional Health Care Boards. You might want to talk over the results of your survey with your county representative. They are responsible for inventorying health services in the regions and incorporating public health should be an important part of that. The total results will be tallied and provided to each of the five regional boards in the hopes that the information will officially be included in the regional resource plans.

RETURN BY JUNE 3

- 11. Please check to make sure you filled out the cover sheet completely and send the survey in the enclosed, stamped envelope BY JUNE 3. Thanks.

**V. UNIVERSAL HEALTH CARE ACCESS PLANS
ACTUARIAL COST ESTIMATION PROJECT**

Montana Health Care Authority

Universal Health Care Access Plans
Actuarial Cost Estimation Project
Final Report

Coopers & Lybrand L.L.P.

September, 1994

September 26, 1994

Mr. Samuel Hubbard
Executive Director
Montana Health Care Authority
28 N. Last Chance Gulch
Helena, MT 59620

Dear Mr. Hubbard:

Re: Cost Estimation Project Final Report

Enclosed is our final report on cost estimates for health care reform alternatives under consideration by the Health Care Authority. Our report summarizes the methods, actuarial assumptions and a range of cost estimates resulting from the Authority's alternatives and these assumptions. We recommend that these results be used carefully by policymakers as an indication of the approximate impact of major new programs.

We appreciate the cooperation and assistance by everyone involved with the Health Care Authority. We are prepared to provide further assistance for the next phase of the program's development.

Sincerely,

John M. Bertko
/s/ JMB

John M. Bertko
Fellow of the Society of Actuaries

Sincerely,

Sandra S. Hunt

Sandra S. Hunt, M. P. A.
Senior Consultant

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SECTION I

Summary of Cost Estimation Project Results

Overview of the Project

The Montana Health Care Authority ("HCA") has undertaken the ambitious task of designing two statewide universal health care reform plans that will meet the needs of the State's residents and the guidelines established by the Montana Legislature. This cost estimation project starts with the work already completed by the Authority in developing initial health care reform alternatives and benefit options and proceeds to develop the first round of cost estimates.

The HCA's charge is to develop a single payer and multiple payer option for universal access plans to be presented to the Montana legislature. To assist in that process health actuaries from Coopers & Lybrand's Human Resources Advisory Group developed baseline cost estimates from the current health care system, tailored a cost projection model to recognize Montana's unique characteristics, and developed sets of assumptions for use in the model. This report describes in detail the key components of the cost estimation model and summarizes the results of this process.

The HCA requested that C&L provide certain information to assist in their decision making process. Specifically, we undertook the following tasks:

- Identified the general benefit designs to be considered as guidelines for the analysis (see Section III for a description.);
- Developed actuarial cost estimates for the critical parts of the benefit designs, including specific covered benefits where appropriate;
- Developed cost estimates for specific population groups including those who are currently insured through private or commercial insurance, those who are covered by Medicaid, Medicare, and the uninsured; and
- Developed a range of assumptions regarding changes in the delivery of health care services and the impact of those changes on projected costs with and without health care reform.

The remainder of this report details our approach, assumptions, and results.

Summary of Results

Based on the Health Care Authority's definitions of the single payer and multiple payer universal access plans, the following table shows the results of the model using best estimate assumptions under current health care delivery arrangements and with the types of reforms assumed in this analysis.

Universal Access Plan Estimated Total Annual Premium Costs With and Without Reform (Millions)				
	Single Payer		Multiple Payer	
	Without Reform	With Reform*	Without Reform	With Reform
1994	\$1,017	\$1,017	\$764	\$764
1995	\$1,145	\$1,145	\$859	\$859
1996	\$1,288	\$1,124	\$833	\$848
1997	\$1,447	\$1,238	\$897	\$929
1998	\$1,608	\$1,347	\$961	\$1,007
1999	\$1,787	\$1,448	\$1,019	\$1,078
2000	\$1,986	\$1,534	\$1,077	\$1,138
2005	\$3,029	\$2,072	\$1,427	\$1,523
* Total cost represents expected premium payments and does not include out-of-pocket cost-sharing.				

Because the single payer alternative has a more comprehensive benefit design than the proposed multiple payer alternative, the single payer alternative has a higher benefit cost (the amount that would need to be collected through benefits or taxes to fund the system). Because people tend to curtail some use of services when cost sharing is required, the total costs of the system (including both premium amounts and out-of-pocket payments) will continue to be higher under the proposed single payer alternative than under the multiple payer alternative, although the differences are less when all costs are considered. The following table shows a summary of the expected premium and out-of-pocket costs for the reform scenarios.

**Single Payer and Multiple Payer Universal Access Plans
Monthly Per Capita Premium and Out-of-Pocket Cost Estimates**

	Single Payer Average Monthly Per Capita <u>Benefit Cost</u>	Single Payer Average Monthly Per Capita <u>Out-of-Pocket Cost</u>	Multiple Payer Average Monthly Per Capita <u>Benefit Cost</u>	Multiple Payer Average Monthly Per Capita <u>Out-of-Pocket Cost</u>
1994	\$127	\$19	\$96	\$28
1995	\$142	\$21	\$107	\$32
1996	\$139	\$21	\$105	\$31
1997	\$152	\$22	\$114	\$33
1998	\$164	\$23	\$123	\$34
1999	\$175	\$23	\$130	\$36
2000	\$184	\$24	\$137	\$37
2005	\$241	\$27	\$177	\$43

Acknowledgment of Assistance

We would like to acknowledge the substantial assistance to C&L actuaries by Montana Health Care Authority staff, other state employees, especially those in the Medicaid agency and the Department of Insurance, and representatives of health plans who responded to our requests for input. In particular, Blue Cross Blue Shield of Montana provided significant assistance and data for this analysis. Valuable input was also provided by Health Systems Research (HSR), the State's primary consultant for developing the universal access plans. The assistance provided was invaluable in gathering information and in obtaining an understanding of the current Montana health care system.

SECTION II

Introduction

Facing rising health care costs, state budget constraints and the loss of health insurance by thousands of residents, Montana and several other states are taking up the challenge of improving access to health care services, containing costs, and providing a practical long-term approach to financing health care. In beginning to address this problem, the Montana Legislature established the Montana Health Care Authority to design two alternative health care reform strategies and guide the State through a process for adopting a reform plan that will meet the needs of Montanans and the requirements of the Legislature as set forth in S.B. 285.

The Human Resource Advisory Group of Coopers & Lybrand was engaged by the HCA to provide actuarial estimates of the costs of the alternatives for health care delivery developed by the Authority. This report provides a summary of our results and a detailed description of the assumptions and methods used to develop the cost estimates.

Goals of the Actuarial Estimation of Costs

As requested by the HCA, the consulting actuaries at C&L had two main objectives. First, we were requested to prepare cost estimates for specified levels of health care benefits for all state residents under assumptions of changes in the health care delivery system, including:

- Commercially insured individuals, through either group or individual policies;
- Medicare-eligible beneficiaries;
- Medicaid beneficiaries;
- “Uninsurable” individuals (those who are denied coverage because of pre-existing conditions); and
- The remaining uninsured.

A second main goal was modeling the impact of various cost containment strategies and system changes. Included in this analysis were factors related to:

- Reduction in administrative expense;

- Reduction in cost-shifting and uncompensated care;
- Effect of a single payer environment; and
- Effects of a Managed cooperation environment.

Approach to Cost Estimation

Overview

Developing the cost estimates for Montana required a series of steps including calculation of relative premium rates for different plan designs under consideration, developing Montana-specific assumptions regarding the potential changes in costs that may occur under various health care reform options, and modeling the total system costs based on decisions made by the HCA. Our cost estimation model had to consider the following:

- Experience of related government reform proposals;
- All components of health care pricing and modeling, including the products and premium rates of the commercial managed care industry, costs of health benefit packages, Medicaid programs, and Medicare reimbursement and funding;
- Different simulation approaches; and
- The process of constructing actuarial scenarios to allow consideration of a proper range of cost estimates.

Our approach and methodology addressed these requirements through both actuarial modeling and a process to delineate and choose the key actuarial assumptions for the “what-if” analysis. We believe that an understanding of the actuarial model and the process for choosing key assumptions is important for both interpreting the results of the model and the limitations of this process.

Overview of Assumptions

The complexity of developing actuarial estimates for new programs, whether for commercial insurance products or government health plans, can be illustrated best by the use of scenarios which provide a range of estimates rather than by relying on a single “correct” result. As one example, the government actuaries for the federal Social Security program develop tax rates and long term funding projections through the use of four scenarios: one optimistic, two intermediate and one pessimistic. This range of results allows administrators and Congress to choose what they believe is the most likely (sometimes called the “best estimate”) scenario as well as to understand how much results may vary from the projections.

If the actuarial model uses generally accepted actuarial methods for calculating estimates, then one of the critical tasks is choice of assumptions for the scenarios. The process that C&L used to develop sets of assumptions included the following steps:

- Creating a “baseline” estimate for each universal access plan to represent the costs of providing the universal access plan benefit package to the populations included in the plan with the current delivery system--as if the universal access plan health system reform provisions had not been implemented. This baseline allows us to measure the cost-containment effects of the universal access plan.
- Defining a range to include a pessimistic and an optimistic scenario and a best estimate scenario for the effects of the plan.

The pessimistic scenario was not intended to be a “worst case” environment with the highest possible costs; rather, it was defined as a high cost set of circumstances that could reasonably occur. Similarly, the optimistic scenario was also defined as a low cost environment which was reasonably possible.

- We then asked experts in Montana (i.e., Health Care Authority members and other key players suggested by the Authority) for their input regarding appropriate assumptions.
- Based on our experience both on the federal level and with other states, C&L actuaries prepared a set of recommended assumptions for each of the scenarios.

Many of the scenario issues are common to other states and most to the federal efforts towards health care reform. Because C&L actuaries participated in a review of similar cost estimation efforts at the federal level, we were able to bring a larger national perspective to these issues and attempted to make the Montana assumptions consistent with the thinking of federal researchers and actuaries.

Similarly, C&L experience with health care reform already implemented in Hawaii, California and Oregon provided us with either working models and preliminary cost estimates for several of the population groups or with similar but more detailed analysis. With these resources, we were able to reach what we believe are appropriate assumptions within the time frame of the Montana project.

- We reviewed the method for choosing assumptions with the Health Care Authority and staff and received approval from project staff on a final set of assumptions for use in calculating results from our model.

Expected Results

In addition to describing our work in developing the estimates and the important factors that we reviewed, this report summarizes a major effort to calculate practical and useful cost estimates for assisting staff and residents of Montana in making decisions about how to structure health care reform in Montana. Results fall into two main categories:

- Per capita cost estimates of the monthly health care cost of individuals if they were enrolled in the current commercial health care delivery system; and
- Total system-wide cost estimates if major changes were made in the form of the two universal health care access plans under consideration.

Since the Montana Health Care Authority is still in the stages of developing an overall framework and does not have a detailed structure, these results should be considered approximations. At the same time, we believe there is significant value in comparing cost estimates from the various scenarios. Even if the Authority changes its recommendations significantly, it is very likely that the relative position of the cost estimates now completed would continue to be valid.

Limitations of the Actuarial Modeling Process

Like any other actuarial model that attempts to produce cost estimates for events which have not yet occurred, actual experience **under any scenario including the baseline status quo** is likely to differ from the results shown in this actuarial model. All readers and users of this report should recognize this limitation and should use the results to help assess the direction and magnitude (e.g., large, small or minimal) of any change modeled.

As mentioned above, use of scenarios is an important tool in trying to assess the cost of future events. We emphasize that no single scenario should be relied upon exclusively as a measure of the cost of a change in the future. By using a set of scenarios, we are able to produce a range of results that we believe represents reasonable and possible outcomes.

Similarly, readers should review the assumptions chosen and the reasons for those choices for each of the scenarios. By gaining an understanding of each of the sets of assumptions, a reader will be able to form a personal judgment about how likely that scenario is.

A final caution involves knowing the degree of change from the current system (or working models of health care reform in other states) to the framework of the alternatives modeled for this report. Actuaries can make accurate projections of new products or state programs that involve small variances from well-established current plans. For example, an actuary developing a cost estimate (a premium rate) for a new health care product with a higher deductible but with the same basic plan design can produce cost estimates that have a high degree of reliability.

However, when a program differs considerably from current programs, the degree of reliance on the cost estimates must decrease in proportion to the magnitude of the changes being made. Both universal health care access plans under consideration by the Authority would appear both to expand on current efforts and to make significant changes in some parts of the current health care system.

SECTION III

General Framework of Universal Access Plans

Through a series of meetings, the Montana Health Care Authority has developed a general outline of two universal access plans. The process for designing these plans is beyond the scope of this report, but it is important for readers to understand the general framework for the plans in reviewing the cost estimates.

As Montana Health Care Authority's project actuary, C&L was asked to provide cost estimates for several benefit design options under consideration by the Authority for incorporation into the universal access plan alternatives. These benefit design options are described in greater detail in the paper prepared by HSR entitled "A Comparison of Covered Benefits and Cost Sharing Requirements Under Selected Health Benefits Plans" (March 31, 1994), which was presented to the HCA at its April 1994 Meeting. These options may be briefly described as:

- The Clinton Health Care Plan as proposed to the U.S. Congress. This plan includes relatively comprehensive benefits and has a high and low cost sharing option. However, even the high cost sharing option is lower than that required by many of the popular small group products in Montana.
- The proposed Montana Standard Small Group benefits that were developed as a result of small group market reform. This benefit package is somewhat less generous than the Clinton plan. In particular, preventive services are less comprehensive, and dental, vision, hearing, and skilled nursing services are excluded.
- Blue Cross Blue Shield of Montana's Advantage Plan for small groups. This benefit package is less comprehensive than the other two, with a \$1,000 deductible for hospital services and 50% cost sharing on all services with a maximum \$3,000 out-of-pocket limit.
- A benefit design that combines the common aspects of two proposals developed by different interest groups in Montana. Both rely on a combination of 100% coverage for preventive services and catastrophic costs, with insurance coverage for all other costs. The insurance coverage would be provided in the form of a medical savings account ("MSA") to provide incentive to reduce utilization. Once an individual's MSA reaches a defined level, the individual would be

eligible to make withdrawals from the account provided that all prescribed preventive services have been obtained. Because only limited information on the proposed benefit structure for this plan was available, our analysis was less complete than for the other plan designs.

Requirements of SB 285

Montana Senate Bill 285 provided guidelines to the HCA for developing the universal access plans. From a cost perspective, three of the requirements are key to our analysis:

- The program is to cover all Montanans. As a result of this requirement we have assumed that no one will have the opportunity to opt out of the system. In particular we have not been concerned with the possibility of adverse selection that could occur in a voluntary system, where those people with the greatest need for health insurance would be most likely to purchase insurance, and those with less need may choose to remain outside of the insurance system.
- Growth in health care expenditures is to be limited to the five year average growth rate of the gross domestic product. This growth rate is lower than we would otherwise project, and has limited our assumptions regarding trend rates for some of the modeling.
- A standard payment level is to be established so that providers receive comparable compensation for providing a given service regardless of the payer source. For example, Medicaid payment levels are currently lower than average payment levels for people who are privately insured. Under SB 285, either Medicaid payment levels would increase to private levels, private levels would be reduced to Medicaid levels, or some combination of the two.

Description of Single Payer Model

The basic design of the single payer model relies on a comprehensive benefit package that requires cost sharing at the time services are delivered. Specifically, the benefit design requires a \$200 deductible, and 20% copayment when services are received. An alternative delivery system that is modeled on Health Maintenance Organization-type arrangements is also anticipated. Under the HMO-type delivery system, cost sharing is required in the form of \$10 copayments for professional services. A more detailed description of the proposed benefit design is provided in the Health Care Authority's *Statewide Universal Health Care Access Plans*.

The HCA has proposed a single payer plan that retains competition among health care buyers. This system design is closer to a hybrid between a highly competitive model and the more traditional "pure" single payer model similar to the Canadian system. Under this design, the State (or an agent of the State) would develop all of the criteria for participation under the system, including developing fee schedules, data reporting requirements, and provider practice standards.

The State may also collect premium payments or other funds and distribute those funds to health plans or providers.

Description of Multiple Payer Model

The multiple payer model developed by the HCA provides a less comprehensive benefit design than the single payer model. Under this benefit design, patients will pay a \$1000 deductible for hospital services, and 50% coinsurance to a maximum of \$3,000 per person and \$6,000 per family per year. The multiple payer model is expected to develop in part out of current changes in the health care delivery system in Montana, with increased use of HMOs and other more comprehensive forms of managed care. Under this system, as under the single payer system, all health care providers are to receive comparable payment for similar services. In other words, all participants in the universal access plan will be subject to some form of a fee schedule, including government-sponsored groups such as Medicaid. Standards for data reporting and provider practice standards would also be developed.

Both universal access plans provide comprehensive preventive services coverage with no cost sharing. The preventive benefits are modeled on the recommendations of the U.S. Preventive Services Task Force.

SECTION IV

Calculation of Per Capita Cost Estimates

This section of the report provides an overview of the methods used to calculate baseline per capita costs for the different population groups.

The actuarial method for developing cost estimates relies on several elements:

- o A data source or starting point;
- o Factors for plan adjustments for the various options;
- o Demographic adjustments to recognize the characteristics of the group covered;
- o Geographical variation in costs and utilization; and
- o Differences in delivery system costs.

After developing a starting point using current data for each covered population group, a baseline cost for coverage of these populations under the current commercial delivery system was calculated. Then explicit assumptions about many likely components of Montana health care reform alternatives were chosen to adjust the baseline cost model.

Because we are projecting costs for a period until 2005, adjustments for a baseline cost include a set of assumptions intended to be most likely to occur before effects of other health care reform adjustments are included; parameters included:

- Utilization and cost based on current Montana delivery system results.

The benefit packages proposed as starting points for our analysis are either sold currently in Montana or are very similar to products currently sold. The starting point for our analysis was the State Employee benefit program. That program provides relatively comprehensive coverage, and varies only slightly from the proposed benefit design for the single payer model. The proposed multiple payer model is based on BCBSMT's Advantage 1000 plan, a popular small group benefit design.

- Demographic adjustment factors are needed to adjust for cost differences that are the result of differing enrollment in health plans by age and sex.

Since health care costs generally rise with age, a health plan which has an older average population is likely to have higher health care costs, even if it is as efficient as a similar competitor. We used a set of demographic risk factors to calculate the expected cost difference between our data sources and the entire Montana adult population. Based on our analysis, no adjustments were necessary because the population covered by the state employee plan is similar demographically to the total Montana adult population.

- Geographic adjustments for cost and utilization differences are frequently also important factors in estimating the costs of programs. Although we were made aware of the existence of these differences for rural versus urban and suburban areas in Montana, we judged that there was not enough sensitivity of the results to require geographic adjustments.
- Cost differences arising from differences in health care delivery systems also needed to be recognized.

HMO enrollment in Montana is significantly lower than in many other states. At the time of our analysis only approximately 10,000 Montanans were enrolled in HMOs. Based on data we were able to acquire, it appears that HMO costs are significantly lower than comparable costs for fee-for-service delivery systems. In particular, we found that premium costs for HMO plans are similar to the costs of fee-for-service plans even when the benefit plans are more comprehensive.

Initial Pricing

C&L provided an initial pricing of five plans to assist the Authority in narrowing its benefit design options for the two reform alternatives. As a first step in developing the premium estimates we relied on data showing costs for Montana's state employees. This program covers all state employees and their dependents and provides relatively comprehensive coverage. We also considered premium cost information for other groups of Montanans. To assess the relative premium cost of the different benefit designs, we used detailed premium rate manuals where appropriate (primarily to assess the cost differences of different cost sharing arrangements) and on detailed research reports and claims data to assess the likely costs of covering specific benefits (such as various levels of mental health coverage or preventive benefits.)

One generally accepted method for ranking health benefit plans is to use their "actuarial value." From a common sense perspective, a benefit plan with a small deductible and low amount of coinsurance will be more valuable to a covered individual (excluding consideration of the premium level) and, thus, have a higher actuarial value. In contrast, a health benefit plan with a very large deductible (e.g., a \$1000 deductible) will require a considerable amount of cost sharing by the individual and will have a lower actuarial value. Using generally accepted actuarial

practices, every benefit plan in the same delivery system can be assigned an actuarial value and ranked as being close to or distant from an average benefit plan.

Privately Insured

The privately insured population (“Commercial”) was chosen as the starting point for modeling the benefit options for several practical reasons. First, this population (consisting of non-Medicare individuals with coverage through insurance companies, Blue Cross/Blue Shield, HMOs or self-insured employer plans) has cost data readily available from a variety of sources. Second, the majority of the non-Medicare Montana population are covered under these plans. Third, several of the health benefit options being considered are close in coverage levels to several common commercial plans. Last, many different tools for modeling are available and we could review the results of the option pricing for reasonableness.

We based our initial pricing of the four plans initially under consideration by the Health Care Authority on a combination of sources, including work we had completed for a similar project in Colorado, data on costs of the Montana State Employee Plan, standard actuarial rate manuals, and research on the costs of specific benefits, including preventive care benefits and mental health and chemical dependency coverage. Relativity factors were calculated for each of the plan designs being considered by the HCA.

We compared the resulting cost estimates with actual experience from the Montana State Employee Plan, using costs from the “Executive Health Plan Summary Report” for the period 9/1/91 through 8/31/92, prepared by BCBSMt.

Expenses were grouped into six categories to allow for application of different trend rates by service category, as well as analysis of the cost impact of making changes in specific benefits: Med/Surg (which included Medical/Surgical, Primary/Preventive; Diagnostic/Laboratory/X-Ray; OB/GYN and Maternity, Emergency Room, and Skilled Nursing); Vision, Dental, Prescription Drug, Mental Health and Substance Abuse, and Other.

Once the value of the benefit design under a traditional fee--for-service delivery system was established, we adjusted the expected premium costs to reflect differences in utilization under an HMO. Based on information provided by BCBSMt, we adjusted indemnity monthly health care costs downward by 25% to account for the fact that the benefits will be delivered in managed care environments. This adjustment reflects the lower utilization and provider discounts that are, on average, achieved by managed care delivery systems.

Final Pricing of Universal Health Access Plan Benefit Packages

Several final adjustments were made to the per capita cost estimate after the Health Care Authority decided on which benefit packages it would recommend to be offered under each universal access plan.

The Authority decided to model the “comprehensive benefit package” under the single payer universal access plan on the benefit design developed by the Clinton Administration. We adjusted the monthly health care costs upward because we estimate that there will be some induced demand due to the comprehensiveness of the benefits package and full coverage to be delivered under a single payer. Based on research on the effect of a single payer system on health care utilization, we assumed that both hospital and physician utilization will increase by 10%. Because this is an increase over current levels, we assumed that the new services would be provided at a 60% marginal cost; for a total increase of 6% in the Medical/Surgical portion of monthly health care costs.

The Authority decided to offer a “minimum benefits package” to be covered under the multiple payer universal access plan. This plan is a modification of the BCBSMt Advantage plan benefits. The primary change in the benefits package is a more comprehensive preventive benefits package as recommended by the U.S. Preventive Services Task Force.

Out-of-Pocket Cost Estimates

In addition to premium cost estimates, the HCA was interested in understanding the total cost of the proposed benefit designs, including out-of-pocket costs. Out-of-Pocket costs were calculated based on standard actuarial continuance tables. These tables show total health care costs and the distribution of costs between premium rates and out-of-pocket expenditures.

Adjustments to Average Costs

As noted earlier in this report, to combine various sources of data on an “apples-to-apples” basis, several adjustments are needed. These fall into two major categories: adjustments for differences in the characteristics of the individuals covered and adjustments for health benefit plan differences. (We have chosen to implicitly incorporate any provider payment differences into the actual average plan cost information reported. By using actual average plan costs as a starting point, our modeling is linked to what a “real world” health system costs today rather than making use of theoretical or survey averages.)

Demographic characteristics of covered health plan populations are generally available and were obtained from Current Population Survey data. Because our starting point was data for the State Employees benefits plan, we compared the demographic characteristics of that group to the entire privately insured population in Montana. Based on that analysis, we found that no adjustments were necessary because the demographic characteristics were similar. Other factors have been proposed and studied (e.g., self-reported health status or prior claims usage); however, this type of data is not currently available for the project and methods for using this data are not well established.

The second adjustment for differences in the health plan’s average plan makes use of the actuarial values of the plan discussed earlier. We calculated what those factors should be and then made an adjustment to the previously calculated average cost. The result of applying both of these adjustments allowed us to blend the average cost results together by delivery system as a baseline starting point for all of the modeling for commercial populations.

Induced Demand

Another important concept for modeling new health benefit options is the amount of induced demand for additional services that would occur as covered individuals receive higher benefit coverage than they previously received. While health actuaries have long been aware of increases in utilization which occur as benefit plans provide a higher level of services, for some uninsured or greatly underinsured populations, induced demand may become a major element in the development of option costs.

This induced demand is a particular concern for benefit designs that require only nominal cost sharing. We have assumed an increase in premium costs for the single payer plan due to limited cost sharing requirements. Based on research on the effect of single payer systems, we increase the costs for the medical/surgical component of the premium rates by approximately 6%.

Because the minimum benefit package developed for the multiple payer model requires a significant degree of coinsurance for most services, we did not assume any increases in utilization for the population that currently is covered by private health insurance.

Results

The following table provides a summary of the results of the Pre-change Adult Health Care Costs estimates for the plans initially considered by the Authority, as well as the monthly health care costs for the plans eventually chosen for the two universal health care access plans. For purposes of this report, we have used the words “Pre-change Adult Health Care Costs” to mean the estimated monthly cost for health coverage for an adult under the current health care system for the new plan options. Later in the modeling process, we begin with these monthly health care costs and make important adjustments to the costs to reflect new cost savings which are likely to result from universal access plan implementation.

Commercial Population 1994 Pre-change Adult Monthly Health Care Costs

	<u>HMO</u>	<u>Fee-for-service</u>
Initial Pricing		
Montana State Employee Plan	\$123.51	\$126.68
Clinton Plans (Low/High)	\$126.70	\$119.70
Small Group Reform (HMO/Indemnity)	\$115.55	\$118.85
BCBSMt Advantage	\$84.88	\$87.28
Universal Access Plan Pricing		
Single Payer, Comprehensive Plans	\$132.38	\$125.25
Multiple Payer, Minimum Benefits Plan	\$87.02	\$89.45

* Note that HMO premium costs are higher because of lower out-of-pocket requirements compared to the fee-for-service plans.

For children, based on work from other sources on a state-wide source of data, we estimated that the cost of children covered under commercial insurance arrangements such as those in Montana would be 40% of adult costs. The use of this estimate for the cost of children is based on our review of actual cost data from a state-wide database for a major PPO and HMO carrier in another Western state; comparable data for Montana was not readily available.

Medicare

The Medicare covered population was the next population group valued. Although the Health Care Authority has decided that the Medicare population will be “deemed covered” and not directly subject to the provisions of either universal access plan, we developed cost estimates in a manner that was intended to be comparable to our other cost estimates and that would allow us to estimate cost-shifting should Medicare payments to providers not keep up with payments to providers under the universal access plan.

We began our estimates with data from the Health Care Financing Administration (HCFA) on the Average Adjusted Per Capita Cost (AAPCC) for its Montana beneficiaries. HCFA compiles AAPCC rates as a basis for paying its Medicare Risk (HMO) contractors, which it reimburses at 95% of the per capita costs it would have paid had the population enrolled in the HMO remained in the traditional fee-for-service Medicare program. AAPCC includes all HCFA payments to providers for services covered by Medicare and is compiled on a county-by-county basis. Using Montana population data by county and county AAPCC rates, we created a weighted average AAPCC rate for the State of Montana (\$301 per beneficiary per month).

To estimate the total current cost of Medicare beneficiaries in Montana, in addition to AAPCC costs we also had to account for the current costs of benefits not paid for by the Medicare program, such as beneficiary cost sharing for covered benefits and beneficiary payments for services not covered by Medicare (e.g., drugs). We gathered information on Montana premiums for various levels of coverage under Medicare supplement policies. Using premiums currently charged by BCBSMt for 65 year-olds purchasing various levels of supplemental coverage (ranging from Plan A, which covers Medicare Parts A and B coinsurance plus 365 additional

hospital days for \$37 per month, to Plan J, which covers all of what Plan A covers plus drugs up to \$3000 and preventive care for \$114.40). Supplemental premiums go up as the age of purchase goes up. We estimated that these Medicare costs not directly covered by the Medicare program averaged approximately \$120 per beneficiary per month.

Medicare 1994 Average Monthly Health Care Costs		
	<u>HMO</u>	<u>Fee-for-service</u>
Medicare Benefits Package	\$285.82	\$301.00

Medicaid

Developing cost estimate for the Medicaid population is considerably different from the methods used for estimating the costs for other population groups. In particular, the process requires use of different data and a series of adjustments to reflect comparable benefits. Specific considerations include the following:

- Benefit levels that are considerably different from commercial types of plans;
- Several unique types of eligibility categories, as determined under state and federal law;
- Detailed current experience that includes items not covered under the benefit design options under consideration, including elements of long-term care and certain types of mental health benefits;
- The need to translate per capita costs at Medicaid utilization rates for each of the significant populations into per capita costs at similar utilization but with Commercial payment rates;
- Frequent enrollment and disenrollment which makes calculation of a monthly per capita cost complex and difficult to interpret; and
- Data from the Montana Medicaid agency in a format that was considerably different from other sources, causing problems of comparability and in removing costs for non-covered services.

The Health Care Authority has decided to initially leave the Medicaid program benefits as they are, so that even under the minimum benefit package developed for the multiple payer plan Medicaid recipients would continue to receive their current level of benefits. The HCA did decide, however, that payment levels for Medicaid recipients would increase to commercial payment levels under the universal access plans. As part of the modeling process (described more thoroughly in the next section), we assumed that a portion of the difference in payment levels, also known as the cost shift, would be recaptured through lower trend rates for all health care costs. Because there are no immediate plans for program modification under the universal access

plan proposals, a monthly per capita cost estimate based on the current cost of providing the Medicaid medical benefits was used as input to the model. This amount was then adjusted to reflect current differences in payment levels between Medicaid and private insurers. A total cost shift of 28.3 was assumed for the Medicaid population.

To determine an appropriate current cost estimate for the Medicaid population, we first collected data from the State of Montana Department of Social and Rehabilitation Services on Medicaid program eligibles and on total program expenditures by service category. Data from the State's FY92 HCFA 2082 payment report was summarized by eligibility group. Because we felt that the most fair and comparable representation of costs for this population should exclude long-term care and other benefits outside the scope of the benefit packages under consideration for other populations, the total payments were adjusted to reflect acute medical-care related expenditures only. We excluded expenditures for Intermediate Care Facilities for the Mentally Retarded and for Extended Care Skilled Nursing Facilities, and deleted 80% of total expenditures for Resident Psychiatric, Home Health, and Personal Care services.

Because FY92 eligibility data were not available, we used department data on Active Medicaid Cases for FY 93 and adjusted total eligibles downward by the FY92-FY93 growth rate of approximately 3.9%. Based on data from C&L's work with the Oregon Medicaid program on the average of length of program eligibility by aid category, we estimated the total number of member months of eligibility by aid category for the Montana Medicaid program for FY 92. We divided total expenditures by aid category by this amount to get a weighted average adult cost per member month of \$248.16.

Medicaid Population 1993 Pre-change Adult Monthly Health Care Cost		
	<u>HMO</u>	<u>Fee-for-service</u>
Medicaid	\$240.22	\$248.16

For children, costs are somewhat more expensive for this population than for a commercial population. Based on an analysis of each of the individual categories of Medicaid recipients, we found that a child had costs that were approximately 58% of adult costs. Some of this difference is readily explained by the greater proportion of children in the birth-to-two years age group, where there is substantial utilization of well-baby and immunization services.

Uninsured/Uninsurable

Developing cost estimates for the Uninsured and Uninsurable populations is a challenging task because there is no recognized source of data for a group which, by definition, does not have formal health care coverage. We believe, however, that limited amounts of data are available from which to make reasonable estimates. Part of the approach used here was to segregate the overall Uninsured population into two separate categories:

- “**Uninsurable**” individuals who have been denied coverage by health plans, usually for reasons related to pre-existing health conditions, and
- Other uninsured individuals (“**Uninsured**”) who for reasons of lack of income, access or choice do not have health care coverage.

For the **Uninsurable** population, there are programs in nearly 20 states that provide some type of insurance coverage, usually at highly subsidized rates through a program which is usually run by the private insurance industry. For developing cost estimates for this population in Montana we looked to data from two other states, Minnesota and California. Minnesota has one of the oldest programs in the country with nearly 15 years of experience. While California’s program is relatively new with over three years of experience, it currently has approximately 15,000 enrollees, all in managed care plans.

Based on this experience and on the structure of the programs, we were able to develop a factor which is based on the experience of these two states and appears to be relatively common to many of these programs. Many programs require individuals to pay 125% of “standard” premiums; actual experience is generally in the area of 175% of the premium revenue for an overall cost of about 220% of “standard” premium. We applied this factor to adjust the Commercial premiums developed earlier to obtain a cost estimate for each of benefit design option in indemnity and HMO variations.

The following table summarizes the baseline monthly adult per capita costs:

Uninsurable 1993 Pre-change Adult Monthly Health Care Costs		
	<u>HMO</u>	<u>Fee-for-service</u>
Universal Access Plan Pricing		
Single Payer, Comprehensive Plans	\$313.69	\$289.92
Multiple Payer, Minimum Benefits Plan	\$190.57	\$195.57

For children’s costs, limited experience indicates that costs do not vary greatly by age; individuals that are denied coverage appear to have similar costs at all ages. For purposes of this cost estimate, we assumed that adults and children had the same costs.

We also estimated the size of the **Uninsurable** population using a commonly accepted rule of 1% of the whole State’s population. This number of people was then removed from the overall estimate of Montana residents without health insurance to obtain the number of **Uninsured** as we have defined the group.

For the remaining **Uninsured**, we looked to available but limited data from several programs that are in early stages of operation and at the limited research that is directly applicable. One of the

programs most similar to coverage of an uninsured population is the Washington State Basic Health Plan (“BHP”). Based on conversations with staff at BHP, we understand that costs over the most recent several years for a population of approximately 20,000 people are about 95% of similar populations of the Commercial health plans participating in the program. A program in Hawaii to cover the remaining uninsured there (those not covered by the employer mandate) has had experience which is considerably more favorable than expected. However, the Hawaiian program uses a very limited “basic” benefits program and its experience is probably not directly applicable. The Kaiser Foundation Health Plan’s “Connections” program in Colorado, which covers certain individuals without health insurance who are referred to Kaiser by government agencies, has experience that is somewhat lower than that of the average Kaiser member in Colorado.

Part of the famous study of health insurance by Rand included estimates of the cost of coverage for individuals who were previously uninsured at the time of their inclusion in the study. Although this data is now somewhat dated, the study showed that the cost of this newly covered group was less than that of other similar previously covered groups. It also indicated that there was very little “pent-up demand” by the newly covered individuals.

After review of this information, we used a factor of 95% of Commercial premium rates to represent the estimated costs of this group of Uninsured (without the high cost individuals in the Uninsurable category). This factor reflects both the younger age of this population and the explicit separation of high cost “Uninsurable” individuals into a separate category. The resulting pre-change adult monthly health care costs are as follows:

Uninsured 1993 Pre-change Adult Monthly Health Care Costs		
	<u>HMO</u>	<u>Fee-for-service</u>
Universal Access Plan Pricing		
Single Payer, Comprehensive Plans	\$127.09	\$120.24
Multiple Payer, Minimum Benefits Plan	\$83.54	\$85.87

SECTION V

Modeling Future Costs With and Without Reform

Overview

As described earlier in this report, an important and generally accepted actuarial method for estimating the costs of new benefit programs is the use of scenarios. Using input from the HCA (from meetings and from confidential replies to written data requests), C&L developed sets of assumptions that were approved by HCA staff for each of three scenarios:

- Best estimate,
- Pessimistic, and
- Optimistic.

In addition to assumptions for these three scenarios, C&L also created a “no reform” estimate for each universal access plan. This “baseline” represents the cost of providing the universal access plan benefit package to the populations included in the plan with the current delivery system. This baseline gives us a reference point to measure the cost-containment effects of the universal access plan.

The following discussion describes in detail the kinds of explicit assumptions chosen for our best estimate, pessimistic, and optimistic scenarios. Separate modeling was performed for the proposed single payer and multiple payer systems. Where different assumptions were chosen for the two universal access plans, the differences are noted. Although any of these assumptions may be criticized individually, we believe that, in total, they represent reasonable conjecture about the direction the health care system will take under the proposed Montana universal access plan alternatives.

For each of the three scenarios, the C&L model was able to consider explicitly the following assumptions:

- Pre-change monthly health care costs (unadjusted for universal access plan effects) for adults and children for each major covered group. The development of this assumption was described in detail earlier in this report;
- Trend rates of monthly health care costs;

- Migration of individuals from one delivery system to another over the study period;
- Recovery of revenue generated from a decrease in cost-shifting and uncompensated care;
- Administrative cost savings to either insurers or providers from the universal access system;
- Effects of a single payer framework; and
- Effects of a Managed Cooperation framework.

The assumptions chosen for each of these elements are summarized in the following section of this report.

In developing the assumptions, a number of specific requirements of Montana SB 285 and Montana's circumstances needed to be taken into account; as well as decisions made by the HCA:

- Many parts of Montana have limited access to health care providers. Only 40% of Montana's population live in urban or semi-urban areas.
- Trend rates in Montana have been somewhat lower than national averages over the past 5 years.
- Montana has relatively high concentration of citizens enrolled in a single health plan today; approximately 50% of the insured population is covered by Blue Cross and Blue Shield of Montana.
- SB285 requires that all participants in the universal access plan have equal payment levels for the same services. Therefore, the current lower payment levels for the Medicaid program would need to move up to the higher private levels or a mechanism would need to be developed to limit payment rates for privately insured people. Should the Medicare population be included in the universal access program, those payments levels would also need to increase.
- The HCA chose a single payer model that allows for multiple insurers. This model would potentially allow competition to exist among health plans and providers, but would also retain some additional administrative expense compared to the amount required for a single payer model similar to the Canadian health care system.

- Trend rates for the universal access program are limited based on the 5 year average growth rate in the gross domestic product.

Population Estimates

Population growth assumptions were identical for all of the modeling. For purposes of projecting the number of people covered in each year, we used forecasts from the State Census and Economic Information Center. As a starting point, we distributed the total 1994 Montana population of 832,170 among the following four insurance sources based on an HSR analysis of 1992-1993 Montana Current Population Survey data: commercial insurance, Medicare, Medicaid, and uninsured. We included those Medicare beneficiaries that also have Medicaid or private insurance coverage in the Medicare population. We included both group and individual commercial coverage, coverage through the CHAMPUS program, and those with private coverage in addition to Medicaid or CHAMPUS coverage, in the commercial insurance category. The populations allocated to each insurance source were further distributed to adult and child categories. For the Medicaid population we used information from Medicaid eligibility statistics. The distribution of adults and children for other populations is based on the CPS analyses.

After distributing the Montana population by insurance status, we removed those populations that the Health Care Authority has deemed “covered” and not subject to the provisions of the universal access plans. We removed a total of 63,025 people from the commercial coverage total, including 19,910 CHAMPUS eligibles (1993 enrollment, per HSR research), 31,000 people eligible for services through the Indian Health Service (the tribal reservation population, per HSR research), and 12,115 veterans (veterans using one of Montana’s two Department of Veterans Affairs facilities, per HSR). We were not able to remove the Active Duty Military population, another population deemed covered by the Authority, from our population totals because we did not have population data available.

Initial Population Distribution, 1994

<u>Plan</u>	<u>Adults</u>	<u>Children</u>	<u>Total</u>	<u>% by Plan</u>
Comm Indem	326,307	161,615	487,922	73.3%
Comm HMO	8,714	4,686	13,400	2.0%
Medicaid	29,118	39,822	68,940	10.4%
Medicaid HMO	0	0	0	0.0%
Uninsrd Indem	65,324	22,083	87,407	13.1%
Uninsrd HMO	0	0	0	0.0%
Unsurbl Indem	6,219	2,102	8,322	1.2%
Unsurbl HMO	0	0	0	0.0%
Total	435,681	230,308	665,990	100.0%

The resulting population to be directly included in the Montana universal access plans totaled 665,990, approximately 73% commercial, 10% Medicaid, 13% Uninsured, and 1% Uninsurable.

We allocated 13,400 of the commercial population, approximately 2.6% of the commercial population total, to HMO plans to reflect the 1994 enrollment of BCBSMt Montana's HMO, the only HMO currently operating in the State. No portion of the other populations were allocated to HMO plans in 1994.

Best Estimate Assumptions

The best estimate scenario is the one of the three scenarios chosen that C&L believes is the most likely to occur **if a universal health care access plan is implemented**. Readers should note, however, that it is important to consider the range of results developed by the other scenarios at the same time; the limitations on the actuarial modeling process are significant and readers should not place undue weight on any single modeling estimate. We have assumed that a universal access plan will not be implemented until 1996, so our assumptions represent no change to the current baseline until that year.

1. **Trend** represents the expected increase in per capita costs from year to year. It includes increases due to change in unit prices (medical inflation), changes in utilization and intensity of services, changes in technology, and, for benefit plans, will generally include an effect from "leveraging" of cost-sharing provisions. ("Leveraging" of cost-sharing provision occurs if costs increase but cost-sharing provisions like deductibles remain frozen; for a high deductible plan, leveraging may add 2-3% to the underlying increase in per capita unit costs, as seen in an employer's insurance premium.)

For the first year (1994), the trend factors shown in the following chart use current trends in the Montana marketplace based on input from the Health Care Authority and C&L experience. The average annual trend rates for the following years represent C&L's interpretation of responses from Authority members and the general direction of trends in response to market pressure. Lower trend factors for some market segments reflect the likely results of aggressive cost containment efforts. We assumed that HMO and Fee-for Service trends would be the same in the single payer and multiple payer scenarios because the structure of the single payer allows for continued competition among health plans and carriers. These initial trend rates do not include the effects of additional adjustments to trend under the various scenarios or of global trend caps, which are proposed and modeled under both universal access plans beginning in 1999 at the level of increase in the gross domestic product (GDP).

Average Annual Trend Rate		
	<u>HMO</u>	<u>Fee-for-Service</u>
1994-1995	8%	11%
1995-1996	8%	11%
1996-1997	7%	9%
1997-1998	6%	8%
1998-1999	5%	7%
1999-2000	5%	7%
2000-2005	5%	7%

These initial trend assumptions are adjusted in the model based on the assumptions regarding scenario-specific changes in trend that follow (including adjustments for cost shifting, effect of increased competition and other factors). Because SB 285 limits growth in health care expenditures to the five year average growth in the gross domestic product, the annual trend rates are capped at that rate. GDP trend increases are projected to be 6.1% in 1999 and 5.7% annually from 2000 to 2005, according to data compiled by HSR from Congressional Budget Office, Office of Management and Budget, and consensus data from "Blue Chip Economic Indicators".

2. **Migration** between health plans (from Fee-for-service to HMO plans) reflects individual choice under a universal access plan framework where individuals would choose health plans based on price, quality, benefits, and provider networks. We have assumed that because both universal access plans will continue to allow a choice of health plans and will not discourage the entry of new managed care plans in to the market, migration will occur equally under the single payer and multiple payer options. Depending on how any individual contribution requirements are structured, as wells as how quickly managed care plans develop in Montana, migration assumptions could vary. For the single payer plan in particular we have assumed that the state-funded premium contribution would be based on the lowest cost available plan, and the remaining premium amount would be the responsibility of the individual. At the same time, migration to tightly managed care plans is limited by the population density of Montana.

Migration assumptions were chosen based on the limited data available in the private sector from similar arrangements (such as the CalPERS benefits provided to state workers in California and a similar program in Minnesota). C&L also attempted to consider possible capacity limits in health plans resulting from too rapid shifts in enrollment and from the rural character of Montana. Because 40% of Montanans live in rural areas which may not be covered by managed care

systems, we have limited HMO migration to a maximum of 40% of any population.

We have assumed that the Medicare population will migrate at roughly half the rate of the commercial population, and that the Medicaid, uninsured, and uninsurable populations, because of their predominantly low income status and resulting price sensitivity, will migrate at approximately twice the commercial rate. (Note: Assumptions were developed for all populations, but only those covered by the universal access plan based on the HCA's decisions are included in the summary results.)

The following table shows our migration assumptions:

Migration per Year, Fee-for-Service to HMO							
	<u>1994-95</u>	<u>1995-96</u>	<u>1996-97</u>	<u>1997-98</u>	<u>1998-99</u>	<u>1999-2000</u>	<u>2000-05</u>
Commercial	1.35%	2.05%	5%	5%	5%	5%	21.7%
Medicare	0%	0%	2.5%	2.5%	2.5%	2.5%	13.1%
Medicaid	0%	0%	10%	10%	10%	10%	8.5%
Uninsured	0%	0%	10%	10%	10%	10%	8.5%
Uninsurable	0%	0%	10%	10%	10%	10%	8.5%

The percentages shown in these tables are interpreted to mean that, for example, 1.35% of the Commercial fee-for-service population in 1994 would transfer to HMOs in 1995. An additional 2.05% of the remaining 1995 commercial FFS population would transfer to HMOs in 1996. The final period numbers reflect the total migration cap of 40%.

3. **Recovery of revenue generated from a decrease in cost-shifting and uncompensated care** may be possible if providers realize an increase in revenue from new sources such as universal access plan implementation. Based on research and discussions at a national level, we have assumed that the recovery would be the same for all delivery systems. This assumption is also consistent with SB285's requirement that all insurance plans pay the same rate. We have further assumed that either universal access plan framework would include either significant market pressure or a mechanism for achieving the cost recovery over a period of several years.

We estimated that the current cost shift represents approximately 12% of commercial monthly health care costs by first adjusting total spending to reflect the true cost of providing services to the non-commercial population at commercial rates. Based on data from the Montana Hospital Association, we assumed that the cost differential for hospital services was approximately 23.9%,

and based on data from the Physician Payment Review Commission, we estimated that the cost shift for physician services was 29.1% for Medicare and 32.6% for Medicaid. We weighted hospital and physician costs 50:50 and increased non-commercial population costs to reflect these commercial payment rates. The payment differential represented approximately 12% of monthly health care costs.

The best estimate modeling of the recovery of this 12% cost shift was assumed to be as follows:

Cost Shift Recovery Percentage	
<u>Year</u>	<u>Recovery Percentage</u>
1994-1995	0%
1995-1996	0%
1996-1997	50%
1997-1998	5%
1998-1999	5%
1999-2000	5%
2000-2005	5%

In this scenario, we have assumed that provider fees would be 6% lower than they otherwise would be in 1996 due to more comprehensive coverage. These fee reductions are expected to occur either through voluntary action on the part of providers or through a mandated fee schedule.

We have also included in our best estimate, optimistic, and pessimistic scenarios an assumption about the difference in commercial premium trend rates that would result should the Medicare and/or Medicaid populations not be included in the universal access plans, allowing the current payment differentials between commercial and Medicare and Medicaid populations to continue at their projected levels. Using costs with and without cost shifting as a starting point, the differential in trend rate between commercial monthly health care costs (as assumed above) and government programs (as reflected in current HCFA budget projections) is calculated and added to the commercial premium rate. An additional annual increase of approximately 1.2% in commercial premium trend rates is reflected in our cost estimates for all scenarios, as the HCA has decided to initially exclude the Medicare population from its proposed universal access plans by “deeming” this group covered.

4. **Administrative cost savings** for insurers and/or providers are likely to result from either universal access plan framework. Our best estimate is that without universal access plan implementation, insurer administrative rates would fall from their current percentages to average approximately 12% over the period. We

assume that if the multiple payer access plan were implemented, the administrative rate would be only 11% due to standardized claims forms and other efficiencies. We assume that a single payer system would have administrative rates of 10% due to additional savings from fewer alliances and fewer alliance-plan relations costs. Although some single state payer systems (without the option of multiple health plan buyers that Montana is proposing) have been able to achieve much lower administrative rates (ranging from 2-6%), we believe that neither of the proposed universal access systems would be able to approximate these lower rates because they would still have to run patient billing systems for copays. In addition, we have not estimated how the proposed individual coverage mandate will affect the administrative costs of insurers and employers. It is likely that an increase in the purchase of individual policies may slow or even reverse the potential administrative savings from these plans.

Administrative cost savings in hospitals and physician offices was also considered to be an important assumption under both universal access plans. We assumed that hospitals and physicians might possibly achieve administrative savings of up to 10% of premium due to standardized claims forms, and electronic billing, and the carrier consolidation. For our best estimate scenario, we assume that savings of 7.2% are recaptured by the health plans over the period resulting in lower premium rates. We used this set of assumptions recognizing the likely constraints of the marketplace and the practical requirements of health plan contracting efforts.

5. Effects of a **Managed Cooperation framework**, upon which both the single payer and multiple payer universal access plans build, include greater cost awareness by consumers of their health care premium and out-of-pocket costs. This awareness, in turn, is believed to result in significantly increased competition on price between health plans.

Early evidence in states with some forms of managed cooperation, like California and Minnesota, indicates an impact both on baseline cost and possibly on trend. For purposes of this modeling, we have assumed that the best estimate trend assumption already has an implicit trend reduction over the long term that is at least partially due to a managed cooperation framework.

We assumed for the best estimate scenario that baseline costs would be reduced by a total of 10% for the approximately 40% of the Montana population potentially affected by managed care over a three year period due to competition on price.

Pessimistic Scenario

A pessimistic scenario should be one which reflects assumptions that are reasonably likely and that result in higher costs than the best estimate scenario. The following assumptions summarize the changes made from the best estimate scenario.

1. Trend under a pessimistic scenario is considered to remain at the baseline amount without decreases due to changes from a universal access plan framework. The following table summarizes the trend used:

Average Annual Trend Rates Before Other Adjustments		
	<u>HMO</u>	<u>Fee-for-Service</u>
1994-1995	8%	11%
1995-1996	8%	11%
1996-1997	8%	11%
1997-1998	7%	10%
1998-1999	6%	9%
1999-2000	6%	9%
2000-2005	6%	9%

2. Migration under a pessimistic scenario with individuals resistant to change and possible significant capacity limits is likely to be slower than under the best estimate scenario. The following table summarizes this assumption:

Migration per Year, Fee-for-Service to HMO							
	<u>1994-95</u>	<u>1995-96</u>	<u>1996-97</u>	<u>1997-98</u>	<u>1998-99</u>	<u>1999-2000</u>	<u>2000-05</u>
Commercial	1.35%	2.05%	2.5%	2.5%	2.5%	2.5%	13.1%
Medicare	0%	0%	1.25%	1.25%	1.25%	1.25%	6.4%
Medicaid	0%	0%	5%	5%	5%	5%	26.3%
Uninsured	0%	0%	5%	5%	5%	5%	26.3%
Uninsurable	0%	0%	5%	5%	5%	5%	26.3%

3. Recovery of revenue generated from a decrease in cost-shifting and uncompensated care would be likely to be less and slower under a pessimistic assumption. We have assumed that the following pattern would be possible:

<u>Year</u>	<u>Recovery Percentage</u>
1994-1995	0%
1995-1996	0%
1996-1997	0%
1997-1998	10%
1998-1999	20%
1999-2000	20%
2000-2005	0%

4. Administrative costs under a pessimistic scenario are assumed to increase by 1% (from 11% in the multiple buyer best estimate to 12% and from 10% in the single payor best estimate to 11%) due to increased regulatory and other compliance activities.

For the hospital and physician savings, the pessimistic scenario assumption recognizes recovery of 6.2% savings rather than the best estimate of 7.2%.

5. Managed cooperation savings would continue to recognize the likely 10% decrease in baseline per capita cost but would lengthen the reduction period to the full period between 1996 and 2005 in the model, rather than the three years used in the best estimate.

Optimistic Scenario

An optimistic scenario should be one which reflects assumptions that are reasonably likely and that result in lower costs than the best estimate scenario. The following assumptions summarize the changes made from the best estimate scenario.

1. Trend under an optimistic scenario is assumed to reduce more rapidly to underlying economic assumptions, such as the overall rate of change of the economy (at approximately 6%) or the rate of increase of the overall CPI (at approximately 4%). The following table summarizes the trend used:

Average Annual Trend Rate		
	<u>HMO</u>	<u>Fee-for-Service</u>
1994-1995	8%	11%
1995-1996	8%	11%
1996-1997	6%	8%
1997-1998	5%	7%
1998-1999	4%	6%
1999-2000	4%	6%
2000-2005	4%	6%

2. Migration under an optimistic scenario with individuals provided with large incentives and sufficient capacity in health plans is likely to be greater than under the best estimate scenario. The following table summarizes this assumption:

Migration per Year, Fee-for-Service to HMO							
	<u>1994-95</u>	<u>1995-96</u>	<u>1996-97</u>	<u>1997-98</u>	<u>1998-99</u>	<u>1999-2000</u>	<u>2000-05</u>
Commercial	1.35%	2.05%	10%	5%	5%	5%	17.3%
Medicare	0%	0%	5%	2.5%	2.5%	2.5%	13.1%
Medicaid	0%	0%	20%	10%	10%	10%	3.8%
Uninsured	0%	0%	20%	10%	10%	10%	3.8%
Uninsurable	0%	0%	20%	10%	10%	10%	3.8%

3. Recovery of revenue generated from a decrease in cost-shifting and uncompensated care would likely be greater and faster under an optimistic assumption. We have assumed that the following pattern would be possible:

<u>Year</u>	<u>Recovery Percentage</u>
1994-1995	0%
1995-1996	0%
1996-1997	50%
1997-1998	10%
1998-1999	10%
1999-2000	10%
2000-2005	10%

4. Administrative cost savings under an optimistic scenario would be an additional 1% of insurer costs (from 11% in the best estimate multiple buyer to 10% and from 10% in the best estimate single payer to 9%) due to improved technology and other savings.

Similarly, for the hospital and physician savings, the optimistic scenario assumption recognizes recovery of 8.2%, 1% more than the 7.2% best estimate savings discussed above.

5. Managed cooperation savings would continue to recognize the entire 4% decrease in baseline per capita cost immediately in the first year due to greatly increased price competition between health plans.

SECTION VI

Summary of Results

As noted earlier, results of actuarial modeling of a new program with the magnitude of changes of the proposed Montana universal health care access plans need to be used carefully. C&L actuaries have developed these cost estimates with as much reliance as possible on the actual current market in Montana.

The assumptions summarized in detail in the previous section contain the underlying basis for the cost results displayed in this section. A reader who wishes to question the results should review the underlying assumptions and, if appropriate, determine better assumptions to use.

Preliminary Modeling Round

C&L performed a series of preliminary cost projections based on various benefit plans to assist the Authority in defining its access plan proposals. For the Authority's June meeting we provided a best, optimistic, and pessimistic estimate range for all benefit packages then under consideration. This exercise gave the Authority a chance to view the magnitude of the effects of various modeling assumptions and plan monthly health care costs. In conjunction with our final round of modeling, we provided the Authority with cost estimates for the single payer and multiple payer plans including both with and without the Medicare and Medicaid populations. These estimates assisted the Authority in formulating its final recommendations for the configurations of the two proposed universal access plans.

Single Payer Universal Access Plan Results

Based on the Health Care Authority's description of the single payer universal access plan, the following table shows our modeling results using the comprehensive benefits package (Clinton High and Low cost sharing) and our various sets of scenario assumptions. Recall that the baseline scenario represents the cost of delivering the single payer benefits package in the pre-change environment, not the full health systems cost baseline.

Single Payer Total Annual Premium Cost Estimates
(Millions)

	No Reform Scenario	Best Estimate Scenario	Optimistic Scenario	Pessimistic Scenario
1994	\$1,017	\$1,017	\$1,017	\$1,017
1995	\$1,145	\$1,145	\$1,145	\$1,145
1996	\$1,288	\$1,124	\$1,105	\$1,217
1997	\$1,447	\$1,238	\$1,201	\$1,366
1998	\$1,608	\$1,347	\$1,292	\$1,514
1999	\$1,787	\$1,448	\$1,375	\$1,657
2000	\$1,986	\$1,534	\$1,456	\$1,758
2005	\$3,029	\$2,072	\$1,944	\$2,361

Under the “no reform” scenario, which does not include a trend cap at 1999 as the other scenarios do, total premium costs are projected to increase a total of 198% between 1994 and 2005. This is an average annual growth rate of approximately 10.4%. By comparison, assuming that the single payer universal access plan is implemented in 1996, total premium growth between 1994 and 2005 under the best estimate scenario would total approximately 104%, with an average annual compounded growth rate of approximately 6.7%. Under the optimistic scenario, total premium growth would be reduced to 91%, or approximately 6.1% annually, whereas under the pessimistic scenario, total growth would equal 132%, or approximately 8.0% annually. In 2005, total costs under the optimistic scenario would be 94% of costs under the best estimate, and total costs under the pessimistic scenario would be 114% of the best estimate.

The following table represents our best estimate premium costs on an annual as well as a per capita monthly basis. It also presents the monthly and total out-of-pocket cost sharing that would be paid by beneficiaries for covered benefits. Note that these out-of-pocket costs do not include payments for services not covered by the benefits package, although the out-of-pocket cost estimates are calculated to include the same range of benefits.

**Single Payer Best Estimate Cost Projections,
Including Monthly Per Capita Benefit and Out-of-Pocket Cost Estimates**

	Average Monthly Per Capita Benefit Cost	Average Monthly Per Capita Out-of-Pocket Cost	Total Annual Benefit Costs (millions)	Total Annual Out-of-Pocket Costs (millions)	Total Annual Costs (millions)
1994	\$127	\$19	\$1,017	\$153	\$1,169
1995	\$142	\$21	\$1,145	\$171	\$1,316
1996	\$139	\$21	\$1,124	\$169	\$1,293
1997	\$152	\$22	\$1,238	\$178	\$1,416
1998	\$164	\$23	\$1,347	\$186	\$1,533
1999	\$175	\$23	\$1,448	\$193	\$1,640
2000	\$184	\$24	\$1,534	\$196	\$1,730
2005	\$241	\$27	\$2,072	\$228	\$2,300

Under best estimate assumptions, out-of-pocket costs represent approximately 10% of the total annual costs for this relatively comprehensive benefits package. (The percentage of total costs decreases over the study period because out-of-pocket payments are not subject to insurer administrative costs, as are plan premiums.)

Multiple Payer Universal Access Plan Results

The following table summarizes our modeling results for the Health Care Authority's multiple payer universal access plan with a minimum benefits package (BCBSMt Advantage plan with preventive care benefits). Again, the baseline scenario represents the cost of delivering the minimum benefits package in the pre-change environment, not the full health systems cost baseline.

**Multiple Payer Total Annual Premium Cost Estimates
(Millions)**

	No Reform Scenario	Best Estimate Scenario	Optimistic Scenario	Pessimistic Scenario
1994	\$764	\$764	\$764	\$764
1995	\$859	\$859	\$859	\$859
1996	\$965	\$848	\$833	\$918
1997	\$1,082	\$929	\$897	\$1,028
1998	\$1,200	\$1,007	\$961	\$1,136
1999	\$1,330	\$1,078	\$1,019	\$1,239
2000	\$1,475	\$1,138	\$1,077	\$1,312
2005	\$2,226	\$1,523	\$1,427	\$1,744

If the multiple payer benefits package were delivered in the current health care environment with no universal access plan implemented in 1996 and no resulting GDP trend caps, the total cost of providing the benefits package would increase from \$764 million in 1994 to \$2,226 million in 2005, a total of 191%. Annual growth averages 10.2% under the baseline scenario. Under best estimate assumptions, the multiple payer system would decrease total growth to 99%, an annual growth rate of approximately 6.5%. Under the optimistic scenario, total growth is estimated at 87%, or approximately 5.8% annually, while under the pessimistic scenario, total growth would be approximately 128%, an annual average of approximately 7.8%. In 2005, premium spending totals under the optimistic scenario would be approximately 95% of best estimate totals; pessimistic scenario spending totals would be approximately 115% of best estimate projections.

The following table summarizes per capita monthly and out-of-pocket costs under the best estimate scenario.

Multiple Payer Best Estimate Cost Projections, Including Monthly Per Capita Benefit and Out-of-Pocket Cost Estimates					
	<u>Average Monthly Per Capita Benefit Cost</u>	<u>Average Monthly Per Capita Out-of-Pocket Cost</u>	<u>Total Annual Benefit Costs (millions)</u>	<u>Total Annual Out-of-Pocket Costs (millions)</u>	<u>Total Annual Costs (millions)</u>
1994	\$96	\$28	\$764	\$227	\$990
1995	\$107	\$32	\$859	\$254	\$1,113
1996	\$105	\$31	\$848	\$251	\$1,098
1997	\$114	\$33	\$929	\$268	\$1,197
1998	\$123	\$34	\$1,007	\$283	\$1,290
1999	\$130	\$36	\$1,078	\$296	\$1,374
2000	\$137	\$37	\$1,138	\$305	\$1,443
2005	\$177	\$43	\$1,523	\$371	\$1,894

Out-of-pocket costs represent approximately 20% of the total annual costs due to the relatively lean benefits package. These totals do not include payments for services not-covered by the benefits package, which represent a larger potential group of services under than under the single payer benefits package.

Observations

Several observations may be made in comparing the two universal access plans:

- The total costs of the single payer alternative, primarily because of its comprehensive benefits package, is substantially higher than the cost of the multiple payer alternative throughout the study period. single payer plan total costs were \$2.23 billion more than the multiple payer plan under the best estimate scenario for the period between 1994 and 2000. However, in addition to out-of-pocket costs between 1994 and 2000 totaling \$638 million more than the single payer plan. The multiple payer plan leaves a larger proportion of services and payments entirely outside the universal access system.
- Both universal access plans provide significant cost containment over the current delivery system at baseline. Costs under either universal access system grow an average of approximately 101% under best estimate to approximately 130% in the pessimistic scenario, compared to an average of over 195% in the baseline scenario.
- The multiple payer plan holds average annual growth to a slightly lower level than the single payer plan under best estimate assumptions, approximately 6.7% versus approximately 6.5%.

**VI. BACKGROUND INFORMATION ON
COST AND REVENUE MODELS USED TO PROJECT
THE IMPACT OF UNIVERSAL ACCESS PLANS
IN MONTANA**



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BACKGROUND INFORMATION ON COST AND REVENUE MODELS USED TO PROJECT THE IMPACT OF UNIVERSAL ACCESS PLANS IN MONTANA

Prepared for :

Montana Health Care Authority

Prepared by:

Health Systems Research, Inc.
Washington, D.C.

26 September 1996

Table 1.
ESTIMATED HEALTH CARE SPENDING IN MONTANA 1992

SOURCES OF EXPENDITURES	TOTAL SPENDING (in \$ millions)	SOURCES OF DATA
Blue Cross/Blue Shield of Montana	\$212.9	Information from Blue Cross/Blue Shield Annual Report, includes expenditures for self insured plans administered by Blue Cross/Blue Shield.
All Other Private Insurers	\$191.4	Montana Insurance Department, direct premiums earned by companies licensed in the accident and health category.
Other Self Insured Plans	~\$150.00	Accurate aggregate information on health care spending by self-funded plans not available. Figure is very rough estimate of health expenditures made by self-funded plans not administered by Blue Cross/Blue Shield.
Other Private Sources	~\$60.00	Includes health-related philanthropic contributions and other non-patient care-related provider revenues. Estimate developed by applying percentage of total national expenditures for health services and supplies in 1991 attributed to this category 3.3% to estimate of total health care spending in Montana.
Out of Pocket Spending	\$358.00	Estimate derived by applying percentage of total natural expenditures for health services and supplies in 1992 attributed to this category 19.8% to the estimate of total health care spending in Montana.
Medicaid	\$248.2	Total Medicaid expenditures according to Montana Medicaid 2082's for 1992.
Medicare	\$328.0	Health Care Financing Administration, Office of Direct Reimbursement.
Workers' Compensation (Medical)	\$55.3	Estimate provided by Workers' Compensation Claims Assistance Bureau.
Automobile Insurance (Medical Coverage)	~\$21.0	Assumes 7.8% of auto insurance premiums are applied to medical claims, based upon Montana experience of State Farm Mutual.
Federal Spending		
Indian Health Service	\$87.2	Reported by Indian Health Service, Billings Region
Active Duty Military	\$5.2	Reported by Department of Defense
Veterans Administration	\$37.5	Reported by Veterans Administration

Table 1.
ESTIMATED HEALTH CARE SPENDING IN MONTANA 1992

SOURCES OF EXPENDITURES	TOTAL SPENDING (in \$ millions)	SOURCES OF DATA
CHAMPUS	~ \$12.0	Based upon 1993 spending of \$13.3 million reported by CHAMPUS
Other State and Federal Spending (non-Medicaid)	~ \$25.6	Based upon FY 1991 estimate of \$23.8 million prepared by the Health Services Division, Department of Health and Environmental Sciences. Updated by 7.5% to develop 1992 estimate. The Legislative Fiscal Analysts' Office is preparing an updated estimate of all health care spending by the State of Montana.
Local Health Spending		
Health and Sanitation	\$1.7	Montana Biennial report, figure represents only local taxes specifically earmarked and does not include local health expenditures from general revenues.
Hospital Districts	\$1.2	Montana Biennial report, figure represents only local taxes specifically earmarked and does not include local health expenditures from general revenues.
TOTAL ESTIMATED SPENDING STATEWIDE	\$1,795.20	

Data compiled by Health Systems Research, Inc.

As indicated in the column describing data sources, the vast majority of our payer-specific expenditures are based on actual figures obtained from the payers themselves. In a few cases, figures on actual spending were not available and Montana-specific estimates had to be imputed using a variety of methods. Two of the largest expenditure categories in which such estimates, rather than actual figures, were used are: out-of-pocket spending and expenditures made by self-funded plans.

As there are no good sources of state-specific data for the first of these two figures, we applied to Montana the same percentage of national expenditures for health services and supplies that are attributed to out-of-pocket expenses (19.8%). We attempted to develop a reliable estimate of expenditures made by self-funded plans by first contacting the major third party administrators that operate these plans in Montana, but were unsuccessful in obtaining sufficient information on which to base a statewide estimate. The figure of \$150 million included in Table 1 therefore represents our "best guess" of expenditures made by self-funded plans not administered by Blue Cross and Blue Shield of Montana (BC/BS-administered self-funded plans totalled approximately \$4.3 million in 1993). We would strongly recommend that the state establish some sort of reporting system for collecting information from self-funded plans as part of its unified data system development process.

To project these expenditures forward, we used the following trend assumption:

- For the period from 1992 to 1994, we applied a composite growth factor of 17.5%, which represents an annual growth rate of approximately 8.5%.
- For the period 1994 to 2005, for the sake of consistency, the growth in private health insurance payments are based upon projections of fee-for-service premium increases developed by Coopers and Lybrand, plus a factor for population growth. For other types of health expenditures, we used projections of the annual growth in national health care expenditures developed by the U.S. Health Care Financing Administration's Office of the Actuary, adjusted by a Montana-specific estimate that reflects the historical relationship between the growth in national spending on major cost elements and Montana trends (Levit et al., 1993).

SINGLE PAYER SCENARIO

Projections of statewide health care expenditures through the year are based upon the following methods:

- Annual estimates of both the annual per capita and total program costs of the uniform benefits package covered under the single payer plan, along with the out-of-pocket payments associated with this benefit package, were developed by Coopers & Lybrand. Single payer program costs are trended forward according to the growth assumptions specified in Coopers & Lybrand's report. These include the effect of the imposition of a limit on the growth in this program beginning in 1999 consistent with the provisions of SB 285. See their report for more detail on the assumptions they used to develop these cost estimates.
- HSR developed a set of assumptions concerning which and what percent of the different expenditure sources would be incorporated into (that is, replaced by) a single payer plan. They are the following:
 - All health insurance premiums and payments made by self-insured plans would be replaced by the single payer plan.
 - One-half of Medicaid expenditures would be replaced by the single payer plan. The remainder of program expenditures are estimated to be made for long-term care services and other services not included in the single payer plan's uniform benefit package and therefore would still be incurred.
 - Half of current out-of-pocket expenditures would still be incurred for long-term care and other services not included in the uniform benefit package, and represent expenditures over and above the out-of-pocket payments associated with the single payer benefit package.
 - Half of expenditures falling into the "other state and federal" and "hospital districts" expenditure categories would be replaced by the single payer plan. The remainder would continue to be incurred.
 - Expenditures under certain programs: Medicare, IHS, Workers' Compensation, automobile insurance, the Veterans' Administration, active duty military health care, CHAMPUS, and local spending for health and sanitation are not projected to change as a result of implementation of the single payer plan.
- Those current expenditures not replaced by the single payer program are assumed to continue to be incurred in future years and are trended forward by applying the

Montana-adjusted growth rates described under the baseline scenario. The combination of single payer program benefit costs and related out-of-pocket costs, plus these additional expenditures, equal projected total statewide spending under the single payer scenario.

- The single payer plan becomes operational in 1996. Start-up costs of \$20 million are assumed in 1995.

REGULATED MULTIPLE PAYER SCENARIO

The key assumptions used to develop the costs under the regulated multiple payer scenario are as follows:

- Approximately 87,000 persons are projected to receive premium subsidies under this scenario. This estimate is based upon the following:
 - Estimates of the number of persons under 200% of poverty who are potentially eligible for public subsidies under this scenario were derived from HSR's analysis of the Montana-specific portion of the 1992 and 1993 Current Population Survey.
 - Enrollment rates within the population meeting the income requirement for the subsidy (i.e., the percentages of people projected to actually apply for and receive subsidies) is expected to vary according to the previous insurance status of these people. One hundred percent of the uninsured are projected to enroll and receive subsidies; fifty percent of those currently purchasing individual, non-group insurance; and five percent of those currently covered by some form of group coverage are expected to receive subsidies.
- Total subsidy costs assume that persons under poverty receive full premium subsidies. Sliding scale subsidies are to be provided for enrollees between 100% and 200% of poverty: for estimation purposes, an average fifty percent subsidy for enrollees in this income bracket is assumed.
- The per capita costs of the subsidies assume that these low income persons are covered for the lower costs sharing benefit package identified under the single payer plan. The per capita benefit and out-of-pocket costs of the single payer benefit package developed by Coopers & Lybrand was used in our model.
- Our estimates assume that all children who would otherwise state-financed public subsidies under this scenario are enrolled into the state Medicaid program under the authority of Section 1902(r)(2) of the Social Security Act. Financing of Medicaid coverage of these children is estimated to be split between the federal and state governments at the current Medicaid matching rate (71% federal; 29% state).

- The provision of subsidies and expanded Medicaid coverage is expected to replace out-of-pocket expenditures that would be made by the uninsured. Because subsidies are also expected to be used by low income persons who were purchasing individual coverage on their own or who had employment-based coverage that they or their employer dropped, these subsidies also replace private insurance premiums.

Thus, while the estimated net increase in total statewide health care spending associated with the individual mandate and subsidies is estimated to be roughly \$44.1 million at 1994 price levels, the distributional effects (i.e., the changes in spending by payer) is as follows:

Type of expenditure	Change (in \$ millions)
■ Out-of-pocket payments:	-\$63.0
■ Individual premiums:	+\$39.9
■ Employment-based premiums:	-\$42.2
■ Public subsidies:	+\$81.0
■ Additional state Medicaid payments:	+\$ 8.2
■ Additional federal Medicaid payments:	+\$20.1
■ Net change:	+\$44.1

- The individual mandate/subsidy program takes effect in 1996. Start-up costs of \$5 million are assumed in 1995.
- Beginning in 1996, the impact of reducing cost shifting due to universal coverage and other reforms under this scenario will be to reduce the trend in private insurance premiums and self-funded plan expenditures by one-half a percentage point below the growth trend used in the baseline/no reform scenario. Like the single payer plan, beginning in 1999, the annual growth in the costs of the uniform benefit package under this scenario is projected to be limited to the annual expenditure limit called for in SB 285. This expenditure limit is estimated to be 5.75% and is applied to 75% of total health care premiums and self-funded plan expenditures, the amount estimated to be attributed to the uniform benefit package under this scenario.

REVENUE REQUIREMENTS AND SOURCES

Our model for calculating the new state revenue requirements of the single payer and regulated multiple payer plans include the following assumptions:

- Beginning in 1996, current state expenditures for health care coverage under the state employees and the acute care portion of Medicaid and federal payments for the acute care portion of Medicaid continue to be made available to the state to

finance the single payer system under a maintenance of effort arrangement, although the projected annual rate of growth in these maintenance of effort funds is set at only 6%.

- A four percent contingency is added to the projected cost of state portion of both the single payer plan and the public subsidy payments required under the regulated multiple payer plan. This is to account for unexpected increases in enrollment or utilization, or other factors that might increase costs above projected levels.
- Any surpluses that accrue to the health care trust fund are invested and are projected to generate a return of four percent per annum to the trust fund.
- New taxes are assumed to take effect in the last month of 1995. This is to allow a small reserve fund to be established prior to implementing either the single payer or the multi-payer system.

Baseline Montana Tax Revenue. The model uses 1994 as its base year. In general, the revenue projections use actual 1994 tax revenues provided by the Montana Department of Revenue. There are three exceptions to the use of 1994 revenue figures as the starting point for our projections:

- Payroll tax revenue estimated use as their base year 1996 projections provided by the Montana Department of Revenue.
- Premium tax revenue estimates use 1993 as the base year. The 1993 primary tax revenue information was provided by the Montana Insurance Department.
- The estimates of Blue Cross Blue Shield premiums, which are not currently taxed, are based upon 1992 figures. Information on Blue Cross Blue Shield premiums was provided by the Montana Insurance Department.

Projections of the Growth of the Tax Bases. We assume that, in the absence of any other effects such as those that are detailed below, the Montana economy will grow at the rate of 4 percent per year. This is conservative assumption for the growth of the economy. Higher growth assumptions will yield higher tax revenues. The model makes two significant departures from the assumption of 4 percent growth:

- Insurance Premiums. In the model we assume the Montana's statewide health care expenditures will increase at a rate of 9 percent per year. Since health insurance premiums are related to the growth in health care expenditures, the model assumes that health insurance premiums will increase at the same rate as health care expenditures (9 percent); and,
- Alcohol and Tobacco products. The consumption of alcohol and tobacco products is assumed to be determined, not the growth of the economy, but by the growth of the population. Montana's population is projected to grow at a rate of .7 percent through 1999, and at a rate of .6 percent through 2005 (NPA Data Services, 1992 Regional Economic Projection Series).

Estimates of the Price Elasticity of Specific Items. Any tax on a good or service increases the price of that good or service to consumers. The reduction in the demand for a good or service as a result of higher prices is known as the price elasticity. For example, if a 10 percent increase in a product's price results in a 5 percent reduction in the demand for the product the price elasticity is said to be .5. The smaller the price elasticity, the less the consumption of a good is effected by changes in price. Price elasticity varies depending on the good or service and will effect the revenue that taxes on individual goods and services generate.

In the model we use a number of different price elasticities to account for changes in demand as a result of higher prices. Where available we have used the price elasticity assumptions used by the Congressional Budget Office (CBO) when estimating financing options for national health reform (Grossman et al., 1993). When CBO estimates did not exist, estimates of price elasticity were developed based upon discussions with the Montana Department of Revenue. The elasticity assumptions and their source are listed below:

The following price elasticities are used by the Congressional Budget Office:

- | | |
|--------------------|----|
| ■ Cigarettes | .4 |
| ■ Tobacco Products | .4 |
| ■ Liquor | .8 |

■	Wine	.7
■	Beer	.3

The following elasticity assumptions were developed based upon discussions with the Montana Department of Revenue:

■	Hotel Room Prices	.2
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-We assume that most hotel taxes are borne by non-residents and that and out-of-state individual's decision to travel to Montana is only slightly influenced by hotel prices.

■	Gaming Taxes	.0
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-We assume that increased gaming taxes will have no effect on gaming volume.

■	Coal Taxes	2.0
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-We assume that increase in coal taxes will result in substantial reductions in coal production. An elasticity of 2.0 means that a 15 percent increase in taxes will result in a 30 percent decrease in production. The market for, and the production of, coal is international and small changes in price are likely to lead to substantial shifts in production to sources outside of Montana.

■	Oil Taxes	2.0
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-As with coal taxes, we assume that increase in oil taxes will result in substantial reductions in oil production. As with coal the market for, and the production of, oil is international and small changes in price are likely to lead to substantial shifts in production to sources outside of Montana.

■	Metalliferous Mining Taxes	.5
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-We assume the demand for the products of metalliferous mines are less price sensitive than coal and oil.

Reduction in the Income and Corporate Tax Bases as Result of Higher Taxes. Two factors may lead to reductions in the tax bases for income and corporate taxes as a result of higher taxes:

- Individuals and corporations may perceive the tax burden in Montana as being excessive and "vote with their feet", by relocating to other states. This is a particular concern in Montana where large shares of income and corporate taxes are paid by a small number of individuals and firms. Therefore the decision to relocate by a relatively small number of individuals or firms could have substantial effects on the tax base.
- In response to higher tax rates individuals and corporations may take steps to shield income and earnings from being taxed.

It should be noted that while it makes intuitive sense that changes in state tax rates will effect the state tax base, research that has attempted to measure the negative effects of state taxes on state economies has been inconclusive. In the model we assume that any 1 percent increase in the income or corporate tax will result in a .5 percent decrease in the tax base.

Cross Tax Effects. An increase in one tax can have spill-over effects on other taxes and may offset some of the increased revenue generated by the tax. The best example of this is the effect of the payroll tax on the income tax. Increases in payroll taxes are directly offset by decreases in employee wages. Therefore, any increase in the payroll tax will result in a reduction in wages by the amount of the tax. The lower wages will reduce the income tax base leading to lower income tax collections. In the model we account for this effect by subtracting any new payroll tax revenues from the income tax base.

Effects on Revenues Due to the Elimination of Employer Sponsored Health Insurance

Under a Single Payer System. Under a single payer system employer sponsored health insurance is eliminated, leading to two contradictory effects:

- Tax revenue will be lost due to the elimination of health insurance premium taxes. In the model we account for this by estimating the revenue that would have been generated by health insurance premium taxes (assuming 9 percent growth in premiums as noted earlier) and subtracting that amount from the estimates of new revenues.

- Tax revenue will increase due to the conversion of non-taxable employee compensation to taxable compensation. We assume that funds which employers currently contribute to employee health benefits, either through premium payments or contributions to self-funded plans, will be used by employers to increase employee wages, leading to higher payroll and income tax revenues. In other words, the higher payroll and income tax bases result from converting currently non-taxed employee compensation (the employer contribution to health benefits) and converting it to taxable income (wages). This assumption that the employer contribution to health benefits will convert to wages under a single payer system is consistent with national models.

In quantifying this effect, we estimated the amount of employer-funded health benefits that would be converted into increased, employee wages by subtracting from projections of total health care premiums and self-funded plan expenditures estimates of:

- premiums paid for non-employment based health care coverage; and
- the portion of employment-based health care coverage that is paid by the employee (estimated at 25% of premium).

Finally, we assume that the labor market will not immediately adjust to the elimination of employer paid premiums. Therefore, the conversion of employer contributions to health benefits to wages is assumed to occur over a two year period, 75 percent the first year and 25 percent the second year.

***Adjusted to use C&L trend projections for FFS plans plus population factor (.652)for no reform scenario and for multipayer baseline to which subsidies are added(See C&L report, p.32).
EXPENDITURES IN MONTANA (in millions)
BASELINE VS. SINGLE PAYER

Assumptions:									
Inc. 92-94:	0.175	Combined							
%LTC in Mcaid:	0.5								
Inc. 94-97:	0.094	per annum	1992	1994					
MOE %:	0.05	Estimates	Estimates						
BCBS		\$212.9	\$262.0 (1)						
Other insurers		\$191.4	\$224.9 Est. Mo. Prem						
Other Self Insured Plans		\$150.0	\$176.3 Per Adult						
	subtotal	\$554.3	\$663.2	\$132	31.3%	\$663.2			
Out of Pocket Spending		\$358.0	\$420.7		19.8%	\$420.7	LTC + .15	\$211.7	\$253.4
Other Private Sources		60.0	\$70.5		3.3%	\$70.5	1	\$0.0	
Medicaid		\$248.2	\$291.6		13.7%	\$291.6	0.4	\$145.8	\$174.5
Workers Comp		\$55.3	\$65.0				1	\$0.0	\$0.0
Auto Insurance		\$21.0	\$24.7				1	\$0.0	\$0.0
	subtotal	\$76.3	\$89.7		4.2%			\$0.0	\$0.0
Federal Waivers Needed									
Medicare		\$328.0	\$385.4						
IHS		\$87.2	\$102.5						
Active Duty Military		\$5.2	\$6.1			\$6.1		\$0.0	\$0.0
CHAMPUS		\$12.0	\$14.1			\$14.1		\$0.0	\$0.0
Veterans Administration		\$37.5	\$44.1				1	\$0.0	\$0.0
	subtotal	\$469.9	\$552.1		26.0%	\$20.2		\$20.2	\$24.2
Other State and Federal		\$25.6	\$30.1		1.4%	\$30.1	0.5	\$15.0	\$18.0
Local Spending									
Health & Sanitation		\$1.7	\$2.0					\$0.0	
Hospital Districts		\$1.2	\$1.4			\$1.4	0.5	\$0.7	\$0.8
	subtotal	\$2.9	\$3.4		0.2%	\$1.4		\$0.7	\$0.8
TOTAL:		\$1,795.2	\$2,121.2			\$1,427.2		\$1,056.7	\$1,264.7
Notes:						67%		50%	
(1). 1993 figure of \$240.4 increased by 9%.							less COP:	\$845.0	\$1,011.3

COMPARISON OF PROJECTED SYSTEMS COSTS: NO REFORM AND SINGLE PAYER SYSTEM

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
BASELINE W/O REFORM	\$2,121.2	\$2,332.9	\$2,570.3	\$2,827.3	\$3,094.4	\$3,369.2	\$3,658.5	\$3,964.1	\$4,295.6	\$4,652.5	\$5,028.7	\$5,430.1
COMPARISON: SINGLE PAYER		\$2,587.8	\$2,830.1	\$3,072.4	\$3,311.3	\$3,534.9	\$3,787.8	\$4,051.4	\$4,324.6	\$4,602.0	\$4,886.8	
DIFFERENCE FR. BASELINE:		\$17.5	\$2.8	(\$22.0)	(\$57.9)	(\$123.7)	(\$176.3)	(\$244.2)	(\$327.9)	(\$426.8)	(\$543.3)	
COMPARISON- MULTIPLE PAYER (From Sheet F: Assumes .5 percent reduc in trend & gb for 75% of prom.)	\$2,121.2	\$2,332.9	\$2,622.9	\$2,882.5	\$3,151.1	\$3,397.6	\$3,653.8	\$3,920.9	\$4,207.8	\$4,513.2	\$4,830.3	\$5,164.1
DIFFERENCE FR. BASELINE:		\$52.6	\$55.1	\$56.7	\$28.3	(\$4.7)	(\$97.8)	(\$139.3)	(\$198.4)	(\$266.0)		
BASELINE (DETAIL)												
BCBS	262.0	292.6	326.7	364.7	403.6	442.5	485.2	532.1	583.4	639.7	701.5	769.2
Other insurers	224.9	251.1	280.4	313.0	346.4	379.8	416.5	456.7	500.7	549.1	602.1	660.2
Self Insured	176.3	196.8	219.7	245.3	271.4	297.6	326.4	357.9	392.4	430.3	471.8	517.4
	663.2	740.5	826.7	923.1	1021.4	1120.0	1228.1	1346.6	1476.6	1619.1	1775.4	1946.7
Out of Pocket Spending	420.7	459.4	503.0	549.4	598.1	648.9	701.2	755.2	813.3	875.1	938.6	1005.0
Other Private Sources	70.5	77.0	84.3	92.1	100.2	108.8	117.5	126.6	136.3	146.7	157.3	168.4
Medicaid	291.6	318.5	348.7	380.9	414.6	449.9	486.1	523.5	563.8	606.7	650.7	696.7
Workers Comp	65.0	71.0	77.7	84.9	92.4	100.2	108.3	116.6	125.6	135.2	145.0	155.2
Auto Insurance	24.7	26.9	29.5	32.2	35.1	38.1	41.1	44.3	47.7	51.3	55.1	58.9
	89.7	97.9	107.2	117.1	127.5	138.3	149.4	160.9	173.3	186.5	200.0	214.2
Federal Waivers Needed												
Medicare	385.4	420.9	460.9	503.3	547.9	594.5	642.4	691.9	745.1	801.8	859.9	920.7
IHS	102.5	111.9	122.5	133.8	145.7	158.1	170.8	183.9	198.1	213.2	228.6	244.8
Active Duty Military	6.1	6.7	7.3	8.0	8.7	9.4	10.2	11.0	11.8	12.7	13.6	14.6
CHAMPUS	14.1	15.4	16.9	18.4	20.0	21.8	23.5	25.3	27.3	29.3	31.5	33.7
Veterans Administration	44.1	48.1	52.7	57.5	62.6	68.0	73.4	79.1	85.2	91.7	98.3	105.3
subtotal	552.1	603.0	660.2	721.1	785.0	851.7	920.4	991.2	1067.5	1148.7	1232.0	1319.1
Other State and Federal	30.1	32.9	36.0	39.3	42.8	46.4	50.1	54.0	58.2	62.6	67.1	71.9
Local Spending												
Health & Sanitation	2.0	2.2	2.4	2.6	2.8	3.1	3.3	3.6	3.9	4.2	4.5	4.8
Hospital Districts	1.4	1.5	1.7	1.8	2.0	2.2	2.4	2.5	2.7	2.9	3.1	3.4
subtotal	3.4	3.7	4.1	4.5	4.8	5.3	5.7	6.1	6.6	7.1	7.6	8.1
SINGLE PAYER	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Global budget applied only to services in uniform benefit pkg.			2587.8	2830.1	3072.4	3311.3	3534.9	3787.8	4051.4	4324.6	4602.0	4886.8
Uniform benefits			1124.0	1238.0	1347.0	1448.0	1534.0	1641.6	1749.2	1856.8	1964.4	2072.0
OOP/uniform benefits			169.0	178.0	186.0	193.0	196.0	202.4	208.8	215.2	221.6	228.0
Medicare	385.4	420.9	460.9	503.3	547.9	594.5	642.4	691.9	745.1	801.8	859.9	920.7
IHS	102.5	111.9	122.5	133.8	145.7	158.1	170.8	183.9	198.1	213.2	228.6	244.8
VA	44.1	48.1	52.7	57.5	62.6	68.0	73.4	79.1	85.2	91.7	98.3	105.3
Active duty military	6.11	6.7	7.3	8.0	8.7	9.4	10.2	11.0	11.8	12.7	13.6	14.6
CHAMPUS	14.1	15.4	16.9	18.4	20.0	21.8	23.5	25.3	27.3	29.3	31.5	33.7
WC&Auto	89.7	97.9	107.2	117.1	127.5	138.3	149.4	160.9	173.3	186.5	200.0	214.2
Maid/LTC	145.8	159.3	174.4	190.4	207.3	224.9	243.1	261.8	281.9	303.4	325.4	348.4
Other private sources	70.5	77.0	84.3	92.1	100.2	108.8	117.5	126.6	136.3	146.7	157.3	168.4
Other state fed/not incl.	15.0	16.4	18.0	19.6	21.4	23.2	25.1	27.0	29.1	31.3	33.6	35.9
Hosp. districts/not incl	0.7	0.8	0.8	0.9	1.0	1.1	1.2	1.3	1.4	1.5	1.6	1.7
Other OOP	208.9	228.2	249.8	272.9	297.0	322.3	348.2	375.0	403.9	434.6	466.1	499.1

SINGLE PAYER FINANCING OPTIONS												
Financing Option: Sheet J Opt 1												
1994												
Taxes:												
prv. Yr. Surf												
Collections: 1995 – 1/12 YR.												
Total avail:												
Reinvest excess @												
4.00%												
Cumulat. surplus/deficit:												
range: costrevs												
SINGLE PAYER FINANCING OPTIONS												
Financing Option: Sheet K Opt 2												
1994												
Taxes:												
prv. Yr. Surf												
Collections: 1995 – 1/12 YR.												
Total avail:												
Reinvest excess @												
4.00%												
Cumulat. surplus/deficit:												
range: costrevs												

INDIVIDUAL/INDIVIDUAL MANDATE LOW-COST PROGRAM
Full premium of premium subsidies under poverty, sliding scale 100%-200% FPL.
OOP extends OOP expenses subsidized to be no more than Clinton plan high cost sharing.
Optimistic scenario: low cost sharing from already insured

Assumptions	OOP		Premium		annual	
	Emp. Plan	Indiv. Plan	Emp. Plan	Indiv. Plan	Emp. Plan	Indiv. Plan
Costs in ab. Costs in absence of coverage						
Adult						
Uninsured - Uninsured	\$1,156	\$1,008	\$579	\$579	\$579	\$579
Non-group/Non-group	\$321	\$304	\$161	\$161	\$161	\$161
Group - Group	\$321	\$304	\$161	\$161	\$161	\$161

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	15910	5303	15910	5303	15910	5303
Non-group/Non-group	9001	3000	9001	3000	9001	3000
Group - Group	13409	4470	13409	4470	13409	4470
Subtotal	38320	12773	38320	12773	38320	12773

OPTIMISTIC/PTIMISTIC SCENARIO
Poverty

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	15910	5303	15910	5303	15910	5303
Non-group/Non-group	9001	3000	9001	3000	9001	3000
Group - Group	13409	4470	13409	4470	13409	4470
Subtotal	38320	12773	38320	12773	38320	12773

1-2X poverty - 2X poverty

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	30697	10332	30697	10332	30697	10332
Non-group/Non-group	42147	14048	42147	14048	42147	14048
Group - Group	17903	5999	17903	5999	17903	5999
Subtotal	91137	30379	91137	30379	91137	30379

O.T. 200% P.G.T. 200% P.O.V.

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	30697	10332	30697	10332	30697	10332
Non-group/Non-group	42147	14048	42147	14048	42147	14048
Group - Group	17903	5999	17903	5999	17903	5999
Subtotal	91137	30379	91137	30379	91137	30379

Uninsured - Uninsured

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	30697	10332	30697	10332	30697	10332
Non-group/Non-group	42147	14048	42147	14048	42147	14048
Group - Group	17903	5999	17903	5999	17903	5999
Subtotal	91137	30379	91137	30379	91137	30379

Uninsured - Uninsured

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	30697	10332	30697	10332	30697	10332
Non-group/Non-group	42147	14048	42147	14048	42147	14048
Group - Group	17903	5999	17903	5999	17903	5999
Subtotal	91137	30379	91137	30379	91137	30379

Uninsured - Uninsured

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	30697	10332	30697	10332	30697	10332
Non-group/Non-group	42147	14048	42147	14048	42147	14048
Group - Group	17903	5999	17903	5999	17903	5999
Subtotal	91137	30379	91137	30379	91137	30379

Uninsured - Uninsured

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	30697	10332	30697	10332	30697	10332
Non-group/Non-group	42147	14048	42147	14048	42147	14048
Group - Group	17903	5999	17903	5999	17903	5999
Subtotal	91137	30379	91137	30379	91137	30379

Uninsured - Uninsured

Poverty	Adult		Child		Total	
	Adult	Child	Adult	Child	Adult	Child
Uninsured - Uninsured	30697	10332	30697	10332	30697	10332
Non-group/Non-group	42147	14048	42147	14048	42147	14048
Group - Group	17903	5999	17903	5999	17903	5999
Subtotal	91137	30379	91137	30379	91137	30379

PROJECTED COSTS AND REVENUES (in \$ millions)

MULTIPLE PAYER PLAN Option 1

Tax Revenues from Sheet I

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
State cost of subsidies and new Mcaid match											
Plus contingency fund @ 4.00%	5.0	\$106	\$115	\$126	\$133	\$141	\$149	\$157	\$166	\$176	\$186
Total:		\$4	\$5	\$5	\$5	\$6	\$6	\$6	\$7	\$7	\$7
		\$110	\$120	\$131	\$138	\$146	\$155	\$164	\$173	\$183	\$193

Prem inc. 94-99: 0.09

Prem inc. 99-2005: 0.0575

Base Year new collection: 0.0

Collections: 1995-1/12 YR.

Growth in tax base:

Reinvest excess @

Taxes: prv. Yr. Surplus
4.00% Total avail:
4.00%

Cumulat. surplus/deficit:

	10.8	126.1	130.6	135.4	140.4	145.6	151.1	156.8	162.8	169.1	175.7
	0.0	\$11	\$28	\$41	\$47	\$51	\$52	\$51	\$46	\$37	\$24
	10.8	\$137	\$159	\$176	\$187	\$197	\$203	\$207	\$209	\$206	\$200
		\$27	\$39	\$45	\$49	\$50	\$49	\$44	\$36	\$23	\$6

PROJECTED COSTS AND REVENUES (in \$ millions)

MULTIPLE PAYER PLAN Option 2

Tax revenues from Sheet H

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
State cost of subsidies and new Mcaid match											
Plus contingency fund @ 4.00%	5.0	\$106	\$115	\$126	\$133	\$141	\$149	\$157	\$166	\$176	\$186
Total:		\$4	\$5	\$5	\$5	\$6	\$6	\$6	\$7	\$7	\$7
		\$110	\$120	\$131	\$138	\$146	\$155	\$164	\$173	\$183	\$194

Prem inc. 94-99: 0.09

Prem inc. 99-2005: 0.0575

Base Year new collection: 0.0

Collections: 1995-1/12 YR.

Growth in tax base:

Reinvest excess @

Taxes: prv. Yr. Surplus
4.00% Total avail:
4.00%

Cumulat. surplus/deficit:

	10.8	126.4	131.0	135.9	140.9	146.1	151.6	157.4	163.4	169.7	176.3
	0.0	\$11	\$29	\$41	\$48	\$52	\$54	\$53	\$48	\$40	\$28
	10.8	\$138	\$160	\$177	\$189	\$198	\$206	\$210	\$212	\$210	\$204
		\$27	\$39	\$46	\$50	\$52	\$51	\$46	\$39	\$27	\$11

PROJECTED COSTS AND REVENUES (in \$ millions)

MULTIPLE PAYER PLAN Option 3

Tax reveunes from Sheet G

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
State cost of subsidies and new Mcaid match											
Plus contingency fund @ 4.00%	5.0	\$106	\$115	\$126	\$133	\$141	\$149	\$157	\$166	\$176	\$186
Total:		\$4	\$5	\$5	\$5	\$6	\$6	\$6	\$7	\$7	\$7
		\$110	\$120	\$131	\$138	\$146	\$155	\$164	\$173	\$183	\$194

Prem inc. 94-99: 0.09

Prem inc. 99-2005: 0.0575

Base Year new collection: 0.0

Collections: 1995-1/12 YR.

Growth in tax base:

Reinvest excess @

Taxes: prv. Yr. Surplus
4.00% Total avail:
4.00%

Cumulat. surplus/deficit:

	10.5	125.5	130.4	135.6	141.0	146.6	152.5	158.7	165.2	172.0	179.1
	0.0	\$11	\$27	\$39	\$45	\$50	\$52	\$52	\$49	\$42	\$32
	10.5	\$136	\$158	\$175	\$186	\$196	\$205	\$210	\$214	\$214	\$211
		\$26	\$38	\$44	\$48	\$50	\$50	\$47	\$41	\$31	\$18

MULTIPAYER PLAN/
TOTAL STATEWIDE SPENDING

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
	\$2,121.2	\$2,332.9	\$2,622.9	\$2,882.5	\$3,151.1	\$3,397.6	\$3,653.8	\$3,920.9	\$4,207.8	\$4,513.2	\$4,830.3	\$5,164.1
BCBS	262.0	292.6	325.2	361.5	398.2	424.4	452.5	482.3	514.2	548.1	584.3	622.8
Other Insurers	224.9	251.1	279.1	310.2	341.7	364.3	388.3	414.0	441.3	470.4	501.5	534.5
Self Insured	176.3	196.8	218.7	243.1	267.8	285.5	304.3	324.4	345.8	368.7	393.0	418.9
Subsidies			97.7	108.6	119.6	127.5	135.9	144.9	154.5	164.7	175.5	187.1
Tot, incl new prem & sub in '96	663.2	740.5	920.7	1023.4	1127.3	1201.7	1281.0	1365.6	1455.7	1551.8	1654.2	1763.4

Out of Pocket Spending

	420.7	459.4	427.7	467.1	508.5	551.7	596.2	642.1	691.5	744.1	798.0	854.5
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Other Private Sources

	70.5	77.0	84.3	92.1	100.2	108.8	117.5	126.6	136.3	146.7	157.3	168.4
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Medicaid

	291.6	318.5	382.7	417.9	455.0	493.7	533.4	574.5	618.7	665.8	714.0	764.5
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Workers Comp

	65.0	71.0	77.7	84.9	92.4	100.2	108.3	116.6	125.6	135.2	145.0	155.2
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Auto Insurance

	24.7	26.9	29.5	32.2	35.1	38.1	41.1	44.3	47.7	51.3	55.1	58.9
	89.7	97.9	107.2	117.1	127.5	138.3	149.4	160.9	173.3	186.5	200.0	214.2

Federal Waivers Needed

Medicare
IHS
Active Duty Military
CHAMPUS
Veterans Administration
subtotal

	385.4	420.9	460.9	503.3	547.9	594.5	642.4	691.9	745.1	801.8	859.9	920.7
	102.5	111.9	122.5	133.8	145.7	158.1	170.8	183.9	198.1	213.2	228.6	244.8
	6.1	6.7	7.3	8.0	8.7	9.4	10.2	11.0	11.8	12.7	13.6	14.6
	14.1	15.4	16.9	18.4	20.0	21.8	23.5	25.3	27.3	29.3	31.5	33.7
	44.1	48.1	52.7	57.5	62.6	68.0	73.4	79.1	85.2	91.7	98.3	105.3
	552.1	603.0	660.2	721.1	785.0	851.7	920.4	991.2	1067.5	1148.7	1232.0	1319.1

Other State and
Federal

	30.1	32.9	36.0	39.3	42.8	46.4	50.1	54.0	58.2	62.6	67.1	71.9
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Local Spending

Health & Sanitation
Hospital Districts
subtotal

	2.0	2.2	2.4	2.6	2.8	3.1	3.3	3.6	3.9	4.2	4.5	4.8
	1.4	1.5	1.7	1.8	2.0	2.2	2.4	2.5	2.7	2.9	3.1	3.4
	3.4	3.7	4.1	4.5	4.8	5.3	5.7	6.1	6.6	7.1	7.6	8.1

OPTION: 1

POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A MULTI-PAYER SYSTEM

Type of Tax	SFY	Tax Base	Rate	Collections 1994	Possible Rate Increase	Adjustment A Growth in Base	Adjustment B Elasticity	Adjustment C Cross Tax Effects 1995	Adjustment A Growth in Base	Adjustment C Cross Tax Effects	New Revenue 1998
Income Tax	94	\$5,780,718,600	Marginal tax rate varies between 2% and 11%	\$345,643,403	Increase effective from 8 to 8.9%	\$5,991,145,264	\$5,988,888,595	\$5,988,730,790	\$8,228,454,528	\$8,175,708,074	\$52,278,393
Payroll Tax											
Employers	96 Projected	\$8,099,581,000	0.50%	\$30,497,905		\$5,881,897,341					
Employees	96 Projected	\$6,099,581,000	0.20%	\$12,199,182	Add on	\$5,881,697,341					
Federal Gov Empls	96 Projected	\$502,672,000	0.20%	\$1,005,344	Additional 0.4% to the employer payroll tax	\$483,067,792					
Self Employed	96 Projected	\$1,599,920,000	0.20%	\$3,199,840		\$1,537,523,120	Employee base	\$8,344,765,133	\$2,187,795	\$8,598,555,738	\$27,054,079
Total Employees						\$7,882,288,253	Employee Base	\$7,882,288,253	\$8,197,579,783	\$8,197,578,783	\$0
Corporate Tax	94	\$0	6.75%	\$0	No change	\$0	\$0	\$0	\$0	\$0	\$0
Insurance Premium Tax											
Property & Casualty	93	\$709,090,909	2.75%	\$0	0.00%						
Life & Health	93	\$250,909,090	2.75%	\$0							
Health only	93	\$181,400,000	2.75%	\$0	0.00%	\$0		\$0			
BCBS/indemnity only	92	\$174,576,000	0.00%	\$0	2.75%	\$228,080,983		\$518,102	\$248,428,271		\$6,776,777
Sin Taxes											
Cigarette Tax	94	89,418,000 packs	\$0.18 (per pack)	\$12,495,000	Double the rate to \$0.38 per pack	89,901,912	69,692,208	\$1,042,238	70,180,052	67,894,110	\$11,700,659
Tobacco Products	94	\$10,824,000	12.50%	\$1,328,000	Double the rate to 25%	\$10,688,368	\$10,653,791	\$110,513	\$10,728,368	\$10,236,851	\$1,212,506
Liquor Tax	94	\$39,611,538	28.00%	\$10,298,000	Double the rate to 52%	\$38,888,819	\$38,187,413	\$834,297	\$39,471,794	\$31,945,839	\$6,168,148
Beer Tax	94	800,000 (barrels of beer)	\$4.30 (per barrel of beer)	\$3,263,000	Double the rate to \$8.60 per barrel or \$0.312 per six pack	905,600	804,700	\$288,029	810,333	800,378	\$3,394,918
Table Wine Tax	94	4,774,074 (liters of table wine)	\$0.27 (per liter of table wine)	\$1,289,000	Double the rate to \$0.54 per liter	4,807,493	4,786,876	\$107,682	4,830,252	4,710,704	\$1,238,871
Mining Taxes											
Coal Severance Tax	94	\$0	15.00%	\$41,200,000	No change	\$0	\$0	\$0	\$0	\$0	\$0
Oil Severance Tax	94	\$222,500,000	5.00%	\$11,125,000	No change	\$0	\$0	\$0	\$0	\$0	\$0
Metalliferous Mines Tax	94	\$0	1.85% (effective rate)	\$6,229,000	No change	\$0	\$0	\$0	\$0	\$0	\$0
Other Taxes											
Gaming Tax	94	\$199,380,000	15.00%	\$29,907,000	Increase to 22.5%	\$207,355,200	\$207,355,200	\$1,295,970	\$215,649,408		\$16,173,706
Hotel/Bed Tax	94	\$0	4.00%	\$8,348,998	No change	\$0	\$0	\$0	\$0	\$0	\$0
Total								\$10,832,600			\$126,053,855

OPTION: 1

POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A MULTI-PAYER SYSTEM

Type of Tax	1997 Adjustment A Growth in Base	Adjustment C Cross Tax Effects	New Revenues 1997	1998 Growth in the Base	New Revenues 1998	1999 Growth in the Base	New Revenues 1999	2000 Growth in the Base	New Revenues 2000	2001 Growth in the Base	New Revenues 2001
Income Tax											
Payroll Tax											
Employees											
Employers											
Federal Gov Emps											
Self-Employed	\$6,662,497,968	\$6,662,497,968	\$28,136,242	\$7,136,997,667	\$29,261,691	\$7,422,477,802	\$30,432,159	\$7,719,378,814	\$31,648,445	\$8,028,151,991	\$32,815,423
Total Employees	\$8,525,462,874	\$8,525,462,874	\$0	\$8,666,502,293	\$0	\$9,221,162,385	\$0	\$9,590,006,681	\$0	\$9,973,808,238	\$0
Corporate Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Insurance Premium Tax											
Property & Casualty											
Life & Health											
Health only											
BCBS/Indemnity only	\$268,606,616		\$7,366,667	\$292,761,429	\$8,051,469	\$319,131,758	\$8,776,123	\$347,653,616	\$9,565,974	\$378,160,441	\$10,426,812
Sin Taxes											
Cigarette Tax	68,339,159		\$11,842,984	66,817,533	\$11,925,885	69,299,256	\$12,009,368	69,715,051	\$12,081,422	70,133,341	\$12,153,810
Tobacco Products	\$10,309,306		\$1,220,693	\$10,360,468	\$1,228,540	\$10,453,129	\$1,238,147	\$10,515,848	\$1,245,578	\$10,578,943	\$1,253,048
Liquor Tax	\$32,169,460		\$6,211,323	\$32,384,648	\$6,254,802	\$32,621,409	\$6,298,566	\$32,817,137	\$6,338,377	\$33,014,040	\$6,374,395
Beer Tax	805,980		\$3,418,683	811,822	\$3,442,814	817,303	\$3,468,712	822,207	\$3,487,513	827,141	\$3,508,436
Table Wine Tax	4,743,679		\$1,245,328	4,778,894	\$1,254,045	4,810,323	\$1,262,823	4,838,184	\$1,270,400	4,866,220	\$1,278,022
Mining Taxes											
Coal Severance Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Oil Severance Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Metalliferous Mines Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other Taxes											
Gaming Tax	\$224,275,384		\$18,820,654	\$233,246,400	\$17,493,480	\$242,576,258	\$18,193,219	\$252,276,306	\$18,620,948	\$262,370,478	\$19,877,766
Hotel Bed Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total			\$130,575,873	\$135,378,037		\$140,400,205		\$145,829,848		\$151,102,809	

OPTION: 1
POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A MULTI PAYER SYSTEM

Type of Tax	2002		2003		2004		2005	
	GrowthIn the Base	New Revenues 2002	GrowthIn the Base	New Revenues 2003	GrowthIn the Base	New Revenues 2004	GrowthIn the Base	New Revenues 2005
Income Tax								
	\$7,812,924,282	\$66,055,467	\$8,125,441,233	\$69,897,668	\$8,450,458,882	\$71,445,503	\$8,788,477,237	\$74,303,417
Payroll Tax								
Employers								
Employees								
Federal Gov Empls								
Self Employed	\$8,349,278,070	\$34,232,040	\$8,683,249,193	\$35,601,322	\$9,030,579,161	\$37,025,375	\$9,391,802,327	\$38,508,380
Total Employees	\$10,372,553,805	\$0	\$10,787,455,749	\$0	\$11,218,953,979	\$0	\$11,667,712,139	\$0
Corporate Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Insurance Premium Tax								
Property & Casualty								
Life & health								
Health only								
BCBS/Indemnity only	\$413,284,881	\$11,365,334	\$450,480,520	\$12,388,214	\$491,023,767	\$13,503,154	\$535,215,908	\$14,718,437
Sin Taxes								
Cigarette Tax	70,554,142	\$12,226,834	70,977,466	\$12,300,185	71,403,331	\$12,373,996	71,831,751	\$12,448,240
Tobacco Products	\$10,642,417	\$1,280,568	\$10,706,271	\$1,268,131	\$10,770,509	\$1,275,740	\$10,835,132	\$1,283,394
Liquor Tax	\$33,212,124	\$6,412,642	\$33,411,397	\$6,451,118	\$33,611,665	\$8,488,924	\$33,813,538	\$8,528,783
Beer Tax	832,100	\$3,529,468	837,096	\$3,550,865	842,119	\$3,571,968	847,171	\$3,593,401
Table Wine Tax	4,897,429	\$1,285,691	4,926,813	\$1,293,405	4,956,374	\$1,301,165	4,988,113	\$1,308,872
Mining Taxes								
Coal Severance Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Oil Severance Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Metaliferous Mines Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other Taxes								
Gaming Tax	\$272,885,297	\$20,464,897	\$283,779,909	\$21,283,493	\$295,131,106	\$22,134,833	\$306,836,350	\$23,020,228
Hotel/Bad Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total		\$158,832,861		\$162,834,229		\$169,121,649		\$175,711,241

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Type of Tax	1997		1996		1986		2000		2001		
	Adjustment A Growth in Base	Adjustment C Cross Tax Effects	New Revenues 1997	Growth in the Base	New Revenues 1996	Growth in the Base	New Revenues 1986	Growth in the Base	New Revenues 2000	Growth in the Base	New Revenues 2001
Income Tax	\$42,316,948	\$42,316,948	(\$2,877,552)	\$44,008,625	(\$2,982,655)	\$45,770,011	(\$3,112,361)	\$47,600,811	(\$3,236,655)	\$48,504,843	(\$3,366,329)
Payroll Tax											
Employers											
Employees											
Federal Gov Emps											
Self Employed	\$6,862,497,966	\$6,662,467,966	\$18,671,666	\$7,136,997,987	\$19,626,744	\$7,422,477,802	\$20,411,614	\$7,716,376,614	\$21,226,267	\$8,028,151,991	\$22,077,416
Total Employees	\$6,525,462,974	\$6,525,462,974	\$23,445,076	\$6,666,502,293	\$24,382,881	\$9,221,162,385	\$25,356,197	\$8,590,006,661	\$26,372,524	\$9,673,609,236	\$27,427,425
Corporate Tax	\$1,124,782,070		\$43,444,840	\$1,169,783,752	\$45,182,425	\$1,216,575,103	\$46,989,722	\$1,265,238,107	\$48,666,311	\$1,315,847,631	\$50,624,084
Insurance Premium Tax											
Property & Casualty											
Life & Health											
Health only											
BCBS/Indemnity only	\$266,606,616		\$7,366,667	\$262,781,429	\$6,051,469	\$316,131,756	\$6,776,123	\$347,653,616	\$9,565,974	\$379,160,441	\$10,426,912
Sin Taxes											
Cigarette Tax	68,339,159		\$11,842,984	68,617,533	\$11,925,885	69,298,256	\$12,009,366	69,715,051	\$12,081,422	70,133,341	\$12,153,910
Tobacco Products	\$10,308,306		\$1,220,993	\$10,380,466	\$1,228,540	\$10,453,128	\$1,236,147	\$10,515,846	\$1,245,576	\$10,576,943	\$1,253,049
Liquor Tax	\$32,169,480		\$6,211,323	\$32,394,646	\$6,254,602	\$32,621,408	\$6,296,566	\$32,817,137	\$6,336,377	\$33,014,040	\$6,374,395
Beer Tax	805,960		\$3,416,683	611,622	\$3,442,614	617,303	\$3,466,712	622,207	\$3,487,513	627,141	\$3,508,438
Table Wine Tax	4,743,678		\$1,245,326	4,776,684	\$1,254,045	4,810,323	\$1,262,823	4,838,184	\$1,270,400	4,866,220	\$1,276,022
Mining Taxes											
Coal Severance Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Oil Severance Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Metaliferous Mines Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other Taxes											
Gaming Tax	\$224,275,384		\$16,620,654	\$233,249,400	\$17,493,480	\$242,576,256	\$18,163,216	\$252,278,306	\$18,820,846	\$262,370,476	\$18,677,766
Hotel Bed Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total			\$131,030,687		\$135,651,251		\$140,692,349		\$146,141,477		\$151,635,111

OPTION: 2
POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A MULTIPAYER SYSTEM

Type of Tax	2002		2003		2004		2005	
	Growth in the Base	New Revenues 2002	Growth in the Base	New Revenues 2003	Growth in the Base	New Revenues 2004	Growth in the Base	New Revenues 2005
Income Tax		\$51,485,037 (\$3,500,983)	\$53,544,439 (\$3,641,022)		\$55,686,216 (\$3,786,663)		\$57,913,665 (\$3,936,129)	
Payroll Tax								
Employers								
Employees								
Federal Gov Emps								
Self Employed	\$9,349,278,070	\$22,960,515	\$8,683,249,193	\$23,678,935	\$9,030,579,161	\$24,634,083	\$9,391,602,327	\$25,627,456
Total Employees	\$10,372,553,605	\$28,524,522	\$10,767,455,749	\$29,685,503	\$11,216,953,979	\$30,652,123	\$11,687,712,130	\$32,086,206
Corporate Tax	\$1,366,481,538	\$52,657,047	\$1,423,220,788	\$54,971,329	\$1,480,148,629	\$57,170,162	\$1,539,355,615	\$59,456,969
Insurance Premium Tax								
Property & Casualty								
Life & health								
Health only								
BCBS/indemnity only	\$413,284,881	\$11,365,334	\$450,480,520	\$12,388,214	\$491,023,767	\$13,503,154	\$535,215,906	\$14,716,437
Sin Taxes								
Cigarette Tax	70,554,142	\$12,226,834	70,977,468	\$12,300,195	71,403,331	\$12,373,996	71,831,751	\$12,446,240
Tobacco Products								
Liquor Tax	\$10,842,417	\$1,260,566	\$10,706,271	\$1,268,131	\$10,770,508	\$1,275,740	\$10,835,132	\$1,283,394
Beer Tax	\$33,212,124	\$6,412,642	\$33,411,397	\$6,451,116	\$33,611,665	\$6,489,824	\$33,813,538	\$6,526,763
	632,103	\$3,529,486	637,096	\$3,550,665	642,119	\$3,571,969	647,171	\$3,593,401
Table Wine Tax	4,897,428	\$1,285,691	4,926,813	\$1,293,405	4,956,374	\$1,301,165	4,986,113	\$1,308,972
Mining Taxes								
Coal Severance Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Oil Severance Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Metaliferous Mines Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other Taxes								
Gaming Tax	\$272,865,297	\$20,464,897	\$283,778,909	\$21,283,493	\$295,131,108	\$22,134,633	\$306,936,350	\$23,020,226
Hotel/Bed Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total		\$157,386,558		\$163,409,967		\$168,720,417		\$176,333,660

OPTION 3
POSSIBLE SOURCES OF NEW
TAX REVENUES TO SUPPORT
A MULTI-PAYER SYSTEM

and Jones

Type of Tax	SFY	Tax Base	Rate	Collections 1994	Possible Rate Increase	Adjustment A Growth in Base	Adjustment B Elasticity	Adjustment C Cross Tax effects	Adjustment A Growth in Base	Adjustment C Cross Tax effects	New Revenues 1995	New Revenue 1996
Income Tax	94	\$5,760,716,800	Marginal tax rates vary between 2% and 11%	\$345,643,403	Increase in tax by 25%	\$5,991,145,294	\$5,987,400,788	\$5,987,400,788	\$6,228,898,830	\$8,184,088,914	\$7,465,529	\$89,958,054
Payroll Tax												
Employers	96 Projected	\$8,099,581,000	0.50%	\$30,487,905	No change	\$5,981,687,341						
Employees	96 Projected	\$8,099,581,000	0.20%	\$12,188,182	No change	\$5,981,687,341						
Federal Gov Emps	96 Projected	\$502,872,000	0.20%	\$1,005,344	on the	\$483,087,782						
Self Employed	96 Projected	\$1,599,820,000	0.20%	\$3,188,840	employees	\$1,537,523,120						
Total Employees						\$7,982,288,253	\$7,982,288,253	\$0	\$8,187,578,783	\$8,187,578,783	\$0	\$0
Corporate Tax	94	\$1,020,311,100	6.75%	\$88,870,899	No change	\$1,061,123,544	\$1,061,123,544	\$0	\$1,103,568,468		\$0	\$0
Insurance Premium Tax												
Property & Casualty	83	\$709,090,909	2.75%	\$0	0.00%							
Life & Health	83	\$250,909,090	2.75%	\$0								
Health only	83	\$181,400,000	2.75%	\$0	Tax BC/BS	\$227,402,340						
BCBS/indemnity only	92	\$174,576,000	0.00%	\$0	2.75%	\$228,080,883		\$518,102	246428271 15		\$518,102	\$8,778,777
Sin Taxes												
Cigarette Tax	94	69,416,000 packs	\$0.18 (per pack)	\$12,485,000	Increase the rate to \$0.27 per pack	89901912	89,787,059	\$521,905	70,265,838	88,125,828	\$5,893,578	\$5,893,578
Tobacco Products	94	\$10,624,000	12.50%	\$1,328,000	Increase the rate to 18.75%	\$10,698,388	\$10,678,080	\$55,372	\$10,750,812	\$10,504,440	\$622,825	\$622,825
Liquor Tax	94	\$38,611,538	26.00%	\$10,299,000	Increase the rate to 39%	\$39,888,818	\$39,543,118	\$420,894	\$39,818,817	\$36,023,752	\$3,805,573	\$3,805,573
Beer Tax	94	800,000 (barrels of beer)	\$4.30 (per barrel of beer)	\$3,263,000	Increase the rate to \$8.54 per barrel or \$0.234 per six pack	805,600	805,150	\$144,095	810,788	805,806	\$144,095	\$1,709,118
Table Wine Tax	94	4,774,074 (liters of table wine)	\$0.27 (per liter of table wine)	\$1,289,000	Increase the rate to \$0.405 per liter	4,807,493	4,802,064	\$53,902	4,835,699	4,775,857	\$53,902	\$627,113
Mining Taxes												
Coal Severance Tax	94	\$0	15.00%	\$41,200,000	No change	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Oil Severance Tax	94	\$222,500,000	5.00%	\$11,125,000	No change	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Metalliferous Mines Tax	94	\$0	1.85% (effective rate)	\$8,228,000	No change	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other Taxes												
Gaming Tax	94	\$189,380,000	15.00%	\$29,807,000	Increase to 22.5%	\$207,355,200	\$207,355,200	\$1,295,870	\$215,848,408	\$16,173,708	\$1,295,870	\$16,173,708
Hotel/Bed Tax	94	\$0	4.00%	\$8,348,000	No change	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total								\$10,475,788			\$10,475,788	\$125,487,845

OPTION 3
POSSIBLE SOURCES OF NEW
TAX REVENUES TO SUPPORT
A MULTI-PAYER SYSTEM

Type of Tax	1997			1998			1999			2000			2001		
	Adjustment A	Adjustment C	1997	Growth in the	New Revenues	Growth in the	New Revenues	Growth in the	New Revenues	Growth in the	New Revenues	Growth in the	New Revenues	Growth in the	New Revenues
	Growth in Base	Cross Tax effects	New Revenues	Base	Base	Base	Base	Base	Base	Base	Base	Base	Base	Base	Base
Income Tax															
Payroll Tax															
Employers															
Employees															
Federal Gov Emps															
Self Employed															
Total Employees	\$8,525,462,874	\$6,525,462,874	\$0	\$6,668,502,293	\$0	\$6,221,182,385	\$0	\$9,590,008,681	\$0	\$9,873,609,238	(\$0)				
Corporate Tax	\$1,147,711,225		\$0	\$1,193,619,874	\$0	\$1,241,364,461	(\$0)	\$1,291,018,040	(\$0)	\$1,342,659,801	(\$0)				
Insurance Premium Tax															
Property & Casualty															
Life & Health															
Health only															
BCBS/indemnity only	\$268,608,616		\$7,366,687	\$282,761,429	\$6,051,469	\$316,131,756	\$8,776,123	\$347,853,616	\$6,585,974	\$376,160,441	\$10,428,912				
Sin Taxes															
Cigarette Tax	69,606,607		\$6,035,534	70,097,076	\$6,077,783	70,587,755	\$6,120,328	71,011,262	\$6,157,050	71,437,349	\$6,193,992				
Tobacco Products	\$10,577,671		\$627,288	\$10,652,018	\$631,677	\$10,726,560	\$836,098	\$10,780,940	\$636,815	\$10,855,686	\$643,755				
Liquor Tax	\$38,275,918		\$3,630,812	\$38,528,650	\$3,656,227	\$38,785,559	\$3,661,821	\$37,006,272	\$3,703,912	\$37,226,310	\$3,728,135				
Beer Tax	811,446		\$1,721,082	817,128	\$1,733,128	822,848	\$1,745,261	827,783	\$1,755,733	832,750	\$1,766,287				
Table Wine Tax	4,809,288		\$631,503	4,842,953	\$635,623	4,878,854	\$640,375	4,908,115	\$644,217	4,935,551	\$648,082				
Mining Taxes															
Coal Severance Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
Oil Severance Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
Metaliferous Mines Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
Other Taxes															
Gaming Tax	\$224,275,364		\$16,820,654	\$233,246,400	\$17,493,460	\$242,576,256	\$16,193,219	\$252,279,308	\$16,920,948	\$262,370,476	\$18,877,766				
Hotel Bed Tax	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0				
Total			\$130,410,974	\$135,576,422	\$140,964,827	\$146,827,116									

\$152,531,673

OPTION 3
POSSIBLE SOURCES OF NEW
TAX REVENUES TO SUPPORT
A MULTI-PAYER SYSTEM

and Page

Type of Tax	2002		2003		2004		2005	
	Growth in the Base	New Revenues 2002	Growth in the Base	New Revenues 2003	Growth in the Base	New Revenues 2004	Growth in the Base	New Revenues 2005
Income Tax								
		\$7,824,842,785	\$113,828,902	\$8,137,838,486	\$118,378,976	\$8,483,349,858	\$123,115,177	\$8,801,883,854
								\$128,039,784
Payroll Tax								
Employers								
Employees								
Federal Gov Empe								
Self Employed								
Total Employees		\$10,372,553,605	(\$0)	\$10,787,455,748	(\$0)	\$11,218,953,879	(\$0)	\$11,667,712,139
								\$0
Corporate Tax		\$1,396,366,183	(\$0)	\$1,452,220,841	(\$0)	\$1,510,309,875	(\$0)	\$1,570,722,062
								(\$0)
Insurance Premium Tax								
Property & Casualty								
Life & Health								
Health only								
BCBS/indemnity only	\$413,284,881	\$11,385,334	\$450,480,520	\$12,388,214	\$481,023,767	\$13,503,154	\$535,215,908	\$14,718,437
Sin Taxes								
Cigarette Tax	71,865,873	\$8,231,156	72,297,189	\$8,268,543	72,730,952	\$8,306,154	73,187,338	\$8,343,891
Tobacco Products	\$10,820,820	\$647,817	\$10,888,345	\$651,503	\$11,052,263	\$655,412	\$11,118,578	\$659,344
Liquor Tax	\$37,451,678	\$3,748,492	\$37,678,390	\$3,770,883	\$37,902,448	\$3,783,808	\$38,128,883	\$3,818,371
Beer Tax	837,747	\$1,776,865	842,773	\$1,767,526	847,830	\$1,798,251	852,817	\$1,809,040
Table Wine Tax	4,865,165	\$651,971	4,984,856	\$655,883	5,024,825	\$658,818	5,055,075	\$683,777
Mining Taxes								
Coal Severance Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Oil Severance Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Metalliferous Mines Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Other Taxes								
Gaming Tax	\$272,885,297	\$20,464,897	\$283,778,809	\$21,283,493	\$295,131,108	\$22,134,833	\$308,938,350	\$23,020,226
Hotel Bed Tax	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total		\$158,713,234		\$185,186,123		\$171,866,408		\$178,070,871

OPTION: 1
POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A SINGLE PAYER PLAN

Type of Tax	SFY	Tax Base	Rate	Collections 1994	Possible Rate Increase	Adjustment A Growth in Base	Adjustment B Elasticity	Adjustment C Cross Tax Effects	New Revenues 1995	Adjustment A Growth in Base	Adjustment C Cross Tax Effects	New Revenues 1996
Income Tax	94	\$5,760,719,600	Marginal tax rate varies between 2% and 11%	\$345,643,403	Double marginal rates	\$5,981,145,264	\$5,973,871,080	\$5,973,871,090	\$34,759,044	\$6,212,617,934	\$5,846,204,632	\$386,419,138
Payroll Tax												
Employers	98 Projected	\$8,099,591,000	0.50%	\$30,497,905		\$5,991,697,341						
Employees	98 Projected	\$6,098,591,000	0.20%	\$12,189,182	Add an additional 7.3%	\$5,991,697,341						
Federal Gov Emps	96 Projected	\$502,972,000	0.20%	\$1,005,344		\$483,067,792						
Self Employed	96 Projected	\$1,599,920,000	0.20%	\$3,199,840	tax on employers	\$1,537,523,120	Employee base	\$6,344,795,133	\$0	\$9,598,555,739	\$8,940,090,538	\$504,626,809
Total Employees						\$7,982,288,253	Employee base	\$7,682,288,253	\$0	\$9,197,579,783	\$8,539,114,583	\$0
Corporate Tax	94	\$1,020,311,100	9.75%	\$88,970,999	Double the effective rate	\$1,081,123,544	\$1,058,139,134	\$5,835,245	\$5,835,245	\$1,100,464,999	\$1,068,419,073	\$68,475,702
Insurance Premium Tax												
Property & Casualty	93	\$709,090,909	2.75%	\$19,500,000	0.00%							
Life & health	93	\$250,909,090	2.75%	\$9,900,000								
Health only	93	\$191,400,000	2.75%	\$5,283,500	0.00%	\$227,402,340		\$0	\$0	\$247,668,551		(\$6,918,385)
BCBS/Indemnity only	92	\$174,576,000	0.00%	\$0	2.75%							
Sin Taxes												
Cigarette Tax	94	69,419,000 packs	\$0.19 (per pack)	\$12,495,000	Double the rate to \$0.36 per pack	99,901,912	99,692,206	\$1,042,238	\$1,042,238	70,180,052	67,964,110	\$11,760,959
Tobacco Products	94	\$10,624,000	12.50%	\$1,328,000	Double the rate to 25%	\$10,698,369	\$10,853,791	\$110,513	\$110,513	\$10,728,368	\$10,236,951	\$1,212,506
Liquor Tax	94	\$39,611,538	26.00%	\$10,299,000	Double the rate to 52%	\$39,689,619	\$39,187,413	\$834,287	\$834,287	\$39,471,794	\$31,945,839	\$9,198,146
Beer Tax	94	800,000 (barrels of beer)	\$4.30 (per barrel of beer)	\$3,283,000	Double the rate to \$8.60 per barrel or \$0.312 per six pack	905,800	804,700	\$288,029	\$288,029	910,333	600,378	\$3,394,919
Table Wine Tax	94	4,774,074 (liters of table wine)	\$0.27 (per liter of table wine)	\$1,299,000	Double the rate to \$0.54 per liter	4,907,493	4,786,678	\$107,892	\$107,892	4,930,252	4,710,704	\$1,238,071
Mining Taxes												
Coal Severance Tax	94	\$274,966,667	15.00%	\$41,200,000	Double the rates to 30%	\$295,653,333	\$279,512,000	\$3,392,133	\$3,392,133	\$299,952,480	\$209,996,048	\$19,437,494
Oil Severance Tax	94	\$222,500,000	5.00%	\$11,125,000	Double the rates to 10%	\$231,400,000	\$227,543,333	\$932,029	\$932,029	\$236,945,067	\$193,260,138	\$7,293,214
Metalliferous Mines Tax	94	\$338,702,703	1.95% (effective rate)	\$9,229,000	Double the rates to 3.7%	\$350,170,911	\$349,900,897	\$539,014	\$539,014	\$383,996,923	\$360,911,360	\$9,612,735
Other Taxes												\$0
Gaming Tax	94	\$189,380,000	15.00%	\$29,907,000	Double the rate to 30%	\$207,355,200	\$207,355,200	\$2,591,940	\$2,591,940	\$215,649,409	\$223,925,184	\$32,347,411
Hotel/Bed Tax	94	\$208,700,000	4.00%	\$8,348,000	Double the rate to 8%	\$217,046,000	\$216,903,301	\$722,529	\$722,529	\$225,579,433	\$223,925,184	\$9,017,158
Total							Full year revenue		\$51,254,891			\$1,053,195,978

OPTION 1
POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A SINGLE PAYER PLAN

Type of Tax	1997 Adjustment A GrowthIn Base	Adjustment C Cross Tax Effects	New Revenues 1997	1998 GrowthIn the Base	New Revenues 1998	1998 GrowthIn the Base	2000 GrowthIn the Base	New Revenues 2000	2001 GrowthIn the Base	New Revenues 2001
Income Tax		\$113,844,833								
	\$6,588,759,427	\$6,167,402,006	\$412,860,898	\$6,414,098,068	\$429,478,334	\$6,870,662,010	\$8,837,468,490	\$464,524,847	\$7,214,988,030	\$483,105,841
Payroll Tax										
Employers										
Federal Gov Emps										
Self Employed	\$7,217,694,159	\$7,331,538,093	\$535,202,354	\$7,624,600,656	\$556,810,448	\$7,929,782,883	\$8,248,984,390	\$602,029,860	\$8,576,663,768	\$626,111,055
Total Employees	\$8,880,879,168	\$6,894,524,099	\$0	\$9,354,305,063	\$0	\$9,728,477,268	\$10,117,616,358	\$0	\$10,522,321,011	\$0
Corporate Tax	\$1,106,075,636		\$72,254,730	\$1,153,438,869	\$75,144,919	\$1,188,578,424	\$1,247,559,481	\$61,278,745	\$1,297,481,660	\$84,527,815
Insurance Premium Tax										
Property & Casualty										
Life & Health										
Health only	\$270,178,720		(\$7,429,660)	\$294,492,625	(\$8,098,547)	\$320,898,861	\$349,686,666	(\$9,621,664)	\$381,376,490	(\$10,487,653)
BCBS/Indemnity only										
Sin Taxes										
Cigarette Tax	68,339,159		\$11,842,984	68,617,533	\$11,925,865	69,299,258	69,715,051	\$12,061,422	70,133,341	\$12,153,810
Tobacco Products	\$10,308,308		\$1,220,993	\$10,380,466	\$1,229,540	\$10,453,128	\$10,515,848	\$1,245,576	\$10,578,943	\$1,253,049
Liquor Tax	\$32,189,460		\$6,211,323	\$32,394,646	\$6,254,802	\$32,621,408	\$32,617,137	\$6,336,377	\$33,014,040	\$6,374,395
Beer Tax	605,880		\$3,416,063	611,622	\$3,442,814	617,303	622,207	\$3,467,513	627,141	\$3,508,436
Table Wine Tax	4,743,679		\$1,245,328	4,778,864	\$1,254,045	4,810,323	4,839,184	\$1,270,400	4,868,220	\$1,278,022
Mining Taxes										
Coal Severance Tax	\$218,387,970		\$19,174,894	\$227,133,889	\$19,941,894	\$236,219,244	\$245,668,014	\$21,568,261	\$255,494,735	\$22,432,031
Oil Severance Tax	\$200,890,543		\$7,584,942	\$209,030,165	\$7,868,340	\$217,391,372	\$226,067,026	\$6,532,029	\$235,130,508	\$6,873,310
Metalliferous Mines Tax	\$375,243,836		\$6,877,244	\$380,253,568	\$7,152,334	\$405,663,733	\$422,096,262	\$7,735,984	\$438,662,213	\$6,045,403
Other Taxes										
Gaming Tax	\$224,275,384		\$33,641,308	\$233,248,400	\$34,986,880	\$242,576,256	\$252,279,306	\$37,841,696	\$262,370,476	\$39,355,572
Hotel/Bed Tax	\$232,692,192		\$9,240,211	\$242,167,478	\$8,609,819	\$251,885,376	\$261,960,794	\$10,393,880	\$272,439,225	\$10,809,740
Total			\$1,113,446,131	\$1,156,622,466		\$1,201,694,931	\$1,246,703,886		\$1,297,340,727	

OPTION: 1
POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A SINGLE PAYER PLAN

Type of Tax	2002		2003		2004		2005	
	Growth in the Base	New Revenues 2002	Growth in the Base	New Revenues 2003	Growth in the Base	New Revenues 2004	Growth in the Base	New Revenues
Income Tax								
	\$7,503,587,551	\$502,430,075	\$7,803,731,053	\$522,527,276	\$8,115,660,295	\$543,426,368	\$8,440,515,507	\$585,185,504
Payroll Tax								
Employers								
Employees								
Federal Gov Empls								
Self Employed	\$8,616,638,316	\$651,155,487	\$9,276,735,648	\$677,201,717	\$9,647,805,283	\$704,288,788	\$10,033,717,494	\$732,461,377
Total Employees	\$10,943,213,651	\$0	\$11,380,942,405	\$0	\$11,836,160,101	\$0	\$12,308,827,305	\$0
Corporate Tax	\$1,349,360,334	\$87,908,927	\$1,403,334,748	\$81,425,284	\$1,459,468,138	\$95,082,296	\$1,517,848,883	\$98,886,587
Insurance Premium Tax								
Property & Casualty								
Life & Health								
Health only	\$415,700,374	(\$11,431,760)	\$453,113,407	(\$12,480,619)	\$493,683,614	(\$13,582,074)	\$538,344,039	(\$14,804,461)
BCBS/Indemnity only								
Sin Taxes								
Cigarette Tax	70,554,142	\$12,226,634	70,977,480	\$12,300,185	71,403,331	\$12,373,998	71,831,751	\$12,448,240
Tobacco Products	\$10,642,417	\$1,260,586	\$10,706,271	\$1,268,131	\$10,770,508	\$1,275,740	\$10,836,132	\$1,283,384
Liquor Tax	\$33,212,124	\$8,412,642	\$33,411,397	\$6,451,118	\$33,611,885	\$6,488,824	\$33,813,538	\$8,528,783
Beer Tax	832,103	\$3,528,486	837,098	\$3,550,665	842,116	\$3,571,966	847,171	\$3,593,401
Table Wine Tax	4,897,429	\$1,285,691	4,926,813	\$1,293,405	4,956,374	\$1,301,165	4,988,113	\$1,308,972
Mining Taxes								
Coal Severance Tax	\$265,714,524	\$23,328,312	\$276,343,105	\$24,282,485	\$287,396,828	\$25,232,884	\$298,692,702	\$26,242,304
Oil Severance Tax	\$244,535,728	\$9,228,242	\$254,317,157	\$9,597,372	\$264,489,843	\$9,881,267	\$275,069,437	\$10,380,517
Metalliferous Mines Tax	\$456,541,502	\$8,367,218	\$474,603,162	\$8,701,906	\$493,785,288	\$9,048,984	\$513,547,100	\$9,411,883
Other Taxes								
Gaming Tax	\$272,865,297	\$40,628,795	\$283,778,909	\$42,566,888	\$295,131,106	\$44,289,668	\$308,938,350	\$48,040,452
Hotel/Bed Tax	\$283,336,794	\$11,242,129	\$294,670,266	\$11,891,814	\$308,457,077	\$12,159,487	\$316,715,360	\$12,845,686
Total		\$1,347,874,656		\$1,400,377,739		\$1,454,924,458		\$1,511,581,901

OPTION 2
POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A SINGLE PAYER PLAN

Type of Tax	SFY	Tax Base	Rate	Average Price Assumptions	Cigarettes \$2.00 per pack Beer \$3.50/66.25 sixbarrel	Table Wine \$7.00 per liter	1995 Adjustment A Growth in Base	Adjustment B Elasticity	1005 New Revenues Cross Tax Effects	11 months Adjustment A Growth in Base	Applying Elasticity to Year 02 0.08 Adjustment C Cross Tax Effects	0.92 New Revenues Cross Tax Effects
Income Tax												
Income Tax	04	\$5,760,716,600	Marginal tax rate varies between 2% and 11%	\$345,643,403	Double marginal rates	\$5,081,145,264	\$5,083,056,332	\$5,083,056,332	\$14,021,998	\$6,223,002,598	\$5,701,002,137	\$147,423,729
Payroll Tax												
Employers	08	\$8,099,581,000	0.50%	\$30,497,905		\$5,881,697,341					\$341,534,800	
Employees	08	\$8,099,581,000	0.20%	\$12,199,162	Add on	\$5,991,697,341						
Federal Gov Emps	08	\$502,672,000	0.20%	\$1,005,344	Additional 0.9% to the employer tax	\$483,087,762						
Self Employed	08	\$1,599,920,000	0.20%	\$3,199,840		\$1,537,523,120	Employee base		\$0	\$8,598,555,738	\$8,940,090,538	\$887,068,963
Total Employees						\$7,882,288,253	Employee base		\$0	\$8,197,570,783	\$8,539,114,583	\$0
Corporate Tax	04	\$1,020,311,100	6.75%	\$69,870,989	Double the effective rate	\$1,061,123,544	\$1,058,139,134		\$5,935,245	\$1,100,494,999	\$1,066,410,073	\$98,475,702
Insurance Premium Tax												
Property & Casualty	93	\$709,090,909	2.75%	\$10,500,000	0.00%							
Life & health	93	\$250,909,000	2.75%	\$8,900,000								
Health only	93	\$191,400,000	2.75%	\$5,283,500	0.00%	\$227,402,340			\$0	\$247,868,551		(\$6,816,395)
BCBS/indemnity only	92	\$174,576,000	0.00%	\$0	2.75%							
Sin Taxes												
Cigarette Tax	04	69,416,000 packs	\$0.18 (per pack)	\$12,495,000	Double the rate to \$0.38 per pack	69,901,912	\$69,992,206		\$2,087,821	70,180,052	67,964,110	\$23,976,199
Tobacco Products	04	\$10,624,000	12.50%	\$1,329,000	Double the rate to 25%	\$10,998,368	\$10,653,791		\$221,490	\$10,729,368	\$10,239,651	\$2,492,087
Liquor Tax	04	\$39,811,536	26.00%	\$10,299,000	Double the rate to 52%	\$39,986,919	\$39,197,413		\$1,693,574	\$39,471,764	\$31,945,839	\$14,474,064
Beer Tax	04	600,000 (barrels of beer)	\$4.30 (per barrel of beer)	\$3,283,000	Double the rate to \$8.60 per barrel or \$0.312 per six pack	905,600	804,700		\$578,378	910,333	800,379	\$8,839,543
Table Wine Tax	04	4,774,074 (liters of table wine)	\$0.27 (per liter of table wine)	\$1,289,000	Double the rate to \$0.54 per liter	4,907,493	4,796,678		\$215,807	4,830,252	4,710,704	\$2,508,561
Mining Taxes												
Coal Severance Tax	04	\$274,648,997	15.00%	\$41,200,000	Double the rates to 30%	\$295,853,333	\$279,512,000		\$3,392,133	\$299,952,480	\$209,998,048	\$18,437,494
Oil Severance Tax	04	\$222,500,000	5.00%	\$11,125,000	Double the rates to 10%	\$231,400,000	\$227,543,333		\$632,029	\$236,845,067	\$193,200,138	\$7,293,214
Metalliferous Mines Tax	04	\$336,702,703	1.85% (effective rate)	\$6,229,000	Double the rates to 3.7%	\$350,170,811	\$346,900,867		\$539,014	\$363,896,923	\$380,811,380	\$8,912,795
Other Taxes												\$0
Gaming Tax	04	\$199,380,000	15.00%	\$29,907,000	Double the rates to 30%	\$207,355,200	\$207,355,200		\$5,183,860	\$215,649,408		\$64,894,822
Hotel/Bed Tax	04	\$208,700,000	4.00%	\$8,348,000	Double the rate to 8%	\$217,048,000	\$216,903,301		\$1,445,540	\$225,579,433	\$223,925,184	\$19,040,335
Total							Full Year Revenue		\$37,134,207			\$1,062,518,062

OPTION 2
POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A SINGLE PAYER PLAN

4/4/2011

Type of Tax	1997		1998		1999		2000		2001	
	Adjustment A Growth in Base	Adjustment C Cross Tax Effects 1997	New Revenues 1997	Growth in the Base	New Revenues 1998	Growth in the Base	New Revenues 1999	Growth in the Base	New Revenues 2000	Growth in the Base
Income Tax		\$113,844,933								
	\$8,710,847,185	\$8,098,689,748	\$180,078,814	\$8,342,818,538	\$108,482,071	\$8,598,321,200	\$173,141,354	\$8,860,174,048	\$180,067,008	\$7,134,581,010
										\$187,268,688
Payroll Tax										
Employers										
Employees										
Federal Gov Emps										
Self Employed	\$7,217,694,158	\$7,331,539,083	\$725,822,370	\$7,824,800,858	\$754,855,265	\$7,928,782,883	\$785,049,478	\$8,246,884,390	\$816,451,455	\$8,576,863,768
Total Employees	\$8,860,878,188	\$8,894,524,098	\$0	\$8,354,305,063	\$0	\$9,728,477,266	\$0	\$10,117,616,358	\$0	\$10,522,321,011
										\$0
Corporate Tax	\$1,109,075,838		\$72,254,730	\$1,153,438,888	\$75,144,919	\$1,189,578,424	\$78,150,718	\$1,247,558,481	\$81,270,745	\$1,297,481,860
										\$84,527,815
Insurance Premium Tax.										
Property & Casualty										
Life & Health										
Health only	\$270,178,720		(\$7,429,860)	\$284,492,825	(\$8,098,547)	\$320,898,981	(\$8,827,418)	\$348,888,888	(\$9,821,894)	\$381,378,480
BCBS/indemnity only										(\$10,487,853)
Sin Taxes										
Cigarette Tax	68,338,158		\$24,144,032	68,817,533	\$24,313,040	69,298,256	\$24,483,232	69,715,051	\$24,630,131	70,133,341
										\$24,777,912
Tobacco Products	\$10,308,308		\$2,508,532	\$10,380,488	\$2,527,098	\$10,453,120	\$2,544,788	\$10,515,948	\$2,560,057	\$10,578,843
Liquor Tax	\$32,189,480		\$14,575,382	\$32,394,848	\$14,877,410	\$32,621,408	\$14,780,152	\$32,817,137	\$14,868,833	\$33,014,040
Beer Tax	805,980		\$8,884,399	811,822	\$8,832,589	817,303	\$8,881,117	822,207	\$7,023,004	827,141
										\$7,065,142
Table Wine Tax	4,743,878		\$2,528,121	4,778,884	\$2,543,804	4,810,323	\$2,561,810	4,838,184	\$2,576,960	4,868,220
										\$2,592,442
Mining Taxes										
Coal Severance Tax	\$218,397,870		\$18,174,894	\$227,133,889	\$18,941,994	\$238,218,244	\$20,738,674	\$245,668,014	\$21,589,261	\$255,494,735
										\$22,432,031
Oil Severance Tax	\$200,890,543		\$7,584,942	\$208,030,185	\$7,868,340	\$217,381,372	\$8,203,874	\$226,087,028	\$8,532,029	\$235,130,508
										\$8,673,310
Metalliferous Mines Tax	\$375,243,838		\$8,877,244	\$380,253,589	\$7,152,334	\$405,883,733	\$7,438,427	\$422,098,282	\$7,735,964	\$438,982,213
										\$8,045,403
Other Taxes										
Gaming Tax	\$224,275,384		\$67,282,815	\$233,248,400	\$68,973,920	\$242,576,256	\$72,772,877	\$252,278,306	\$75,883,792	\$282,370,478
										\$78,711,143
Hotel Bed Tax	\$232,882,182		\$18,555,488	\$242,197,479	\$18,297,718	\$251,895,378	\$20,069,827	\$261,960,794	\$20,872,412	\$272,438,225
										\$21,707,309
Total										

OPTION 2
POSSIBLE SOURCES OF NEW TAX
REVENUES TO SUPPORT
A SINGLE PAYER PLAN

Type of Tax	2002		2003		2004		2005	
	Growth in the Base	New Revenues 2002	Growth in the Base	New Revenues 2003	Growth in the Base	New Revenues 2004	Growth in the Base	New Revenues 2005
Income Tax								
Payroll Tax								
Employers								
Employees								
Federal Gov Emps								
Self Employed								
Total Employees								
Corporate Tax								
Insurance Premium Tax								
Property & Casualty								
Life & Health								
Health only								
BCBS/indemnity only								
Sin Taxes								
Cigarette Tax								
Tobacco Products								
Liquor Tax								
Beer Tax								
Table Wine Tax								
Mining Taxes								
Coal Severance Tax								
Oil Severance Tax								
Metalliferous Mines Tax								
Other Taxes								
Gaming Tax								
Hotel Bed Tax								
Total								

**VII. IMPLEMENTATION OF SMALL GROUP
HEALTH INSURANCE REFORM**

STATE AUDITOR
STATE OF MONTANA



COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

Mark O'Keefe
STATE AUDITOR

IMPLEMENTATION OF SMALL GROUP
HEALTH INSURANCE REFORM

Like thirty other states, the 1993 Montana Legislature passed insurance reforms for the small employer groups as part of Senate Bill 285. The Montana Small Employer Health Insurance Availability Act is based on a model act designed by the National Association of Insurance Commissioners. The insurance department of the State Auditor's Office worked on implementation of these reforms beginning July 1993.

A "Special Report on Small Employer Health Insurance Reform" will be presented in January 1995 to the Legislature. This report will be a comprehensive analysis of the small group market and reforms.

Goals of Small-Group Insurance Reform

- * Promoting availability of health insurance, regardless of a business' health status or claims experience;
- * Preventing abusive rating practices and requiring disclosure of rating practices to purchasers;
- * Establishing rules on renewability of coverage;
- * Limiting use of pre-existing condition exclusions; and
- * Improving the overall fairness and efficiency of the small employer health insurance market.

Design of the Standard and Basic Plans

The legislation authorized State Auditor Mark O'Keefe, as Montana's Insurance Commissioner, to appoint the five member Health Benefit Plan Committee. The committee, with input from the public, health care providers, and insurance industry, was charged with designing standard and basic health benefit packages that can be marketed on a voluntary basis to the state's small businesses.

The Health Benefit Plan Committee designed two kinds of health benefit plans: basic (lower-cost) plans and a standard plan. All

plans will include all state-mandated benefits and maternity coverage.

The plans will provide for portability of coverage and guaranteed issue. That means that workers won't be subject to pre-existing condition exclusions if they leave a job and move to another with small-group coverage (portability), and that insurance companies can't reject a group for coverage because of its health history or for any other reason (guaranteed issue).

Insurance carriers that offer small group plans (basic and standard plans) will be required to accept all groups, including groups that formerly could not get health insurance for their employees. Companies can still underwrite other health plans. This move is intended to make small-group health insurance more accessible to small businesses.

The committee designed specific benefits to be in every standard plan sold by insurers. The committee recommended a free-market approach to basic plans, allowing insurers to offer a variety of products. The Montana basic plans will allow many current policies to serve as basic plans, thereby ensuring portability of coverage and guaranteed issue.

The committee also devised a preventive care package of benefits based on medical knowledge and common sense. The preventive care package, included in the standard plan, includes well-child care beyond the age of two, age-appropriate checkups, appropriate care linked to family medical history and maternity care reimbursed as a preventive care item rather than as an illness.

Some time after Dec. 7, 1994, insurers will be able to offer a single standard plan and at least one basic plan. Policies will not be sold by the state; they will be sold by private insurance carriers that participate in the small-group market. Businesses are not required to participate.

Businesses wishing to do so can continue their current policies, which may qualify as basic plans under the small group reform act. Or they can apply for other plans. The new law provides businesses and consumers with more choices.

Notice of cancellation of policies must be given at least 180 days prior to termination of coverage. The insurance commissioner will assist small employers whose policies have been cancelled under certain conditions in finding replacement coverage.

Employers and consumers can renew their coverage -- renewability is guaranteed -- unless they fail to pay premiums, commit fraud, or make misrepresentations.

Premium rate increases will be capped, and premium variations will be limited among similar groups and limited between groups. The new law allows rates to vary by a factor of two, a significant change from current rate variations of up to a factor of 10.

Pre-existing condition exclusions will be limited: Pre-existing conditions will be covered after 12 months, and if an individual is continuously covered, no pre-existing condition exclusion period will apply.

The standard plan, estimated to cost about \$160 a month per individual employee, must offer state-mandated and maternity benefits. It will include:

- * An annual deductible of \$250 for an individual, \$500 for family coverage;
- * Coinsurance payments, after the deductible is met, of 20 percent for the insured;
- * Maximum out-of-pocket expenses of \$1,250 a year for individuals and \$2,500 per family;
- * Maximum lifetime benefits of \$1 million;
- * 20-percent coinsurance payments for the insured for prescription drugs;
- * First-dollar coverage (no deductible or copayment) for a package of preventive-care services, such as well-child care from birth to age 20, prenatal care, mammographies, pap smears, health exams, health counseling, and age-appropriate physical exams;
- * Four visits a year to a practitioner of choice, with patient copayment limited to \$25 per visit; and
- * Policies issued to any group that applies.

Any health benefit plan that has fewer benefits than a standard plan will qualify as a basic health benefit plan. All basic (lower-cost) plans must include all state-mandated and maternity benefits. Under this approach, employers and consumers can select from a variety of basic plans and shop for the deductible,

coinsurance, and maximum out-of-pocket levels that meet their particular needs. The theory behind the basic plan is to allow the free market to dictate the components of the policies. All basic plans will be issued to any group that applies for one.

Reinsurance Program

Guaranteed issue will require insurance companies to assume risks that they might otherwise reject. SB 285 set up a state reinsurance program so insurers could buy insurance for their riskier groups or individuals. The program is funded through premiums and assessments paid by insurers.

The Montana Reinsurance Program has a governing board with six representatives from the largest small-group insurance companies and three consumers. The program will be able to issue reinsurance policies beginning December 7, 1994. Travelers Insurance Company is the administrating carrier for the program. Travelers serves in the same capacity for 17 other reinsurance programs throughout the states.

VIII. SCHEDULE AND LOCATION OF PUBLIC PARTICIPATION EVENTS

**SCHEDULE OF
MONTANA HEALTH CARE AUTHORITY MEETINGS**

August 11, 1993
State Capitol Building
Helena

August 20, 1993
Conference Call

September 13, 1993
Conference Call

September 20, 1993
Conference Call

September 28, 1993
Conference Call

October 12, 1993
Conference Call

October 19, 1993
Conference Call

October 29, 1993
Colonial Inn
Helena

November 19, 1993
Montana State University Billings
Billings

November 30, 1993
111 North Last Chance Gulch
Helena

December 17, 1993
Village Red Lion Inn
Missoula

December 27, 1993
Conference Call

January 11, 1993
Conference Call

January 20 and 21, 1994
Colonial Inn
Helena

February 22, 1994
Great Falls Civic Center
Great Falls

March 18, 1994
State Capitol Building
Helena

April 13 and 14, 1994
Moose Lodge
Sidney

May 12 and 13, 1994
State Capitol Building
Helena

June 9 and 10, 1994
Willson School Auditorium
Bozeman

July 28 and 29, 1994
Park Place Auditorium
Miles City

August 15 and 16, 1994
Park Inn
Lewistown

September 22 and 23, 1994
Town House Inn
Butte

**SCHEDULE OF
MONTANA HEALTH CARE AUTHORITY MEETINGS (cont.)**

October 20 and 21, 1994
Grouse Mountain Lodge
Whitefish

November 17 and 18, 1994
Park Plaza Hotel
Helena

December 12 and 13, 1994
Department of Health and
Environmental Sciences
Helena

January 19 and 20, 1995
Park Plaza Hotel
Helena

SCHEDULE OF
REGIONAL HEALTH CARE PLANNING BOARD MEETINGS

Region I Health Care Planning Board

January 21, 1994
1:00 p.m. - 3:00 p.m.
Colonial Inn
Helena

March 7, 1994
10:00 a.m. - 2:00 p.m.
Holiday Lodge
Glendive

May 16, 1994
10:00 a.m. - 2:00 p.m.
Cottonwood Inn
Glasgow

July 16, 1994
11:00 a.m. - 2:30 p.m.
Dawson Community College
Glendive

Public Hearing on Region I Health
Care Resource Management Plan
August 1, 1994 - 10:00 a.m.
Dawson Community College
Glendive

August 1, 1994
10:00 a.m.
Dawson Community College
Glendive

October 11, 1994
10:00 a.m.
Miles City
(Meeting site to be determined.)

Region II Health Care Planning Board

January 21, 1994
1:00 p.m. - 3:00 p.m.
Colonial Inn
Helena

March 22, 1994
10:00 a.m. - 2:00 p.m.
Blue Sky Villa
Conrad

May 18, 1994
10:00 a.m. - 2:00 p.m.
Great Falls Civic Center
Great Falls

June 23, 1994
3:00 p.m. - 6:00 p.m.
Mormon Church
Chester

July 18, 1994
7:00 p.m. - 9:00 p.m.
Havre High School
Havre

Public Hearing on Region II Health
Care Resource Management Plan
July 18, 1994
5:00 - 7:00 p.m.
Havre High School
Havre

**Schedule of
Regional Health Care Planning Board Meetings (cont.)**

Region II Health Care Planning Board (cont.)

September 12, 1994
2:00 p.m. - 6:00 p.m.
Great Falls Civic Center
Great Falls

October 14, 1994
11:00 a.m. - 2:00 p.m.
Choteau Public Library
17 N. Main Avenue
Choteau

Region III Health Care Planning Board

January 21, 1994
1:00 p.m. - 3:00 p.m.
Colonial Inn
Helena

March 9, 1994
10:00 a.m. - 3:00 p.m.
Montana State University - Billings
Billings

April 20, 1994
9:30 a.m. - 1:30 p.m.
Montana State University - Billings
Billings

May 19, 1994
10:00 a.m. - 2:00 p.m.
Montana State University - Billings
Billings

July 15, 1994
11:00 a.m. - 3:00 p.m.
Montana State University - Billings
Billings

Public Hearing on Region III Health
Care Resource Management Plan

August 11, 1994
9:00 a.m.
Transwestern III Building
Billings

August 11, 1994
9:00 a.m.
Transwestern III Building
Billings

September 14, 1994
2:00 pm. - 5:00 p.m.
Montana State University - Billings
Billings

October 10, 1994
2:00 p.m.
Roundup
(Meeting site to be determined.)

Region IV Health Care Planning Board

January 21, 1994
1:00 p.m. - 3:00 p.m.
Colonial Inn
Helena

March 10, 1994
10:00 a.m.
War Bonnet Inn
Butte

**Schedule of
Regional Health Care Planning Board Meetings (cont.)**

Region IV Health Care Planning Board (cont.)

April 23, 1994
1:00 p.m. - 5:00 p.m.
Pilgrim Congregational Church
Bozeman

May 19, 1994
4:00 p.m. - 7:00 p.m.
Western Montana College
Dillon

June 22, 1994
4:00 p.m. - 8:00 p.m.
St. Peter's Community Hospital
Helena

July 14, 1994
2:00 p.m. - 7:00 p.m.
Mountain View Medical Center
White Sulphur Springs

Public Hearing on Region IV Health
Care Resource Management Plan

August 10, 1994
12 noon - 4:00 p.m.
Metcalf Senior Citizens' Center
Anaconda

August 10, 1994
12 noon - 4:00 p.m.
Metcalf Senior Citizens' Center
Anaconda

October 6, 1994
Townsend
(Site and time to be determined.)

Region V Health Care Planning Board

January 21, 1994
1:00 p.m. - 3:00 p.m.
Colonial Inn
Helena

February 28, 1994
11:00 a.m. - 3:00 p.m.
Lake County Courthouse
Polson

March 24, 1994
6:00 p.m. - 10:00 p.m.
Flathead County High School
Kalispell

May 20, 1994
8:30 a.m. - 12:30 p.m.
Cavanaugh's at Kalispell Center
Kalispell

June 30, 1994
11:00 a.m. - 3:00 p.m.
City Hall Council Chambers
Hamilton

August 4, 1994
10:00 a.m. - 2:00 p.m.
Village Red Lion Inn
Missoula

**Schedule of
Regional Health Care Planning Board Meetings (cont.)**

Region V Health Care Planning Board (cont.)

Public Hearing on Region V Health
Care Resource Management Plan
August 4, 1994
5:00 p.m. - 7:00 p.m.
Village Red Lion Inn
Missoula

November 3, 1994
Libby
(Site and time to be determined.)

**SCHEDULE OF
PUBLIC HEARINGS ON
UNIVERSAL HEALTH CARE ACCESS PLANS**

Region I

September 13, 1994
7:00 p.m. - 10:00 p.m.
West Side Elementary School
Sidney

Region IV

September 8, 1994
7:00 p.m. - 10:00 p.m.
Montana State University
Bozeman

Region II

September 12, 1994
7:00 p.m. - 10:00 p.m.
Great Falls Civic Center
Great Falls

Region V

September 7, 1994
7:00 p.m. - 10:00 p.m.
University of Montana
Missoula

Region III

September 14, 1994
7:00 p.m. - 10:00 p.m.
Montana State University - Billings
Billings

September 20, 1994
9:00 a.m. - 12 noon and
1:00 p.m. - 3:00 p.m.
Department of Health and
Environmental Sciences
Helena

**SCHEDULE OF
PUBLIC HEARINGS ON
STATEWIDE AND REGIONAL RESOURCE MANAGEMENT PLANS**

Statewide Public Hearing

September 22, 1994
8:30 am. - 9:30 a.m.
Town House Inn
Butte

Region III Public Hearing

August 11, 1994
9:00 a.m.
Transwestern III Building
Billings

Region I Public Hearing

August 1, 1994
10:00 a.m.
Dawson Community College
Glendive

Region IV Public Hearing

August 10, 1994
12 noon - 4:00 p.m.
Metcalf Senior Citizens' Center
Anaconda

Region II Public Hearing

July 18, 1994
5:00 p.m. - 7:00 p.m.
Havre High School
Havre

Region V Public Hearing

August 4, 1994
5:00 p.m. - 7:00 p.m.
Village Red Lion Inn
Missoula

**SCHEDULE OF
ELECTRONIC CITIZENS' FORUMS**

May 16, 1994
6:30 p.m. - 9:30 p.m.
Cottonwood Inn
Glasgow

May 19, 1994
6:30 p.m. - 9:30 p.m.
Cavanaugh's at Kalispell Center
Kalispell

May 18, 1994
6:30 p.m. - 9:30 p.m.
Great Falls Civic Center
Great Falls

**SCHEDULE OF
TOWN MEETINGS ON THE UNIVERSAL ACCESS PLANS**

Region I

July 26, 1994
7:00 p.m. - 10:00 p.m.
Sherman Motor Inn
Wolf Point

August 1, 1994
7:00 p.m. - 10:00 p.m.
Dawson Community College
Glendive

Region II

July 19, 1994
7:00 p.m. - 10:00 p.m.
Great Falls Civic Center
Great Falls

July 20, 1994
7:00 p.m. - 10:00 p.m.
Roger's Saloon
Malta

Region III

August 16, 1994
7:00 p.m. - 10:00 p.m.
Park Inn
Lewistown

August 17, 1994
7:00 p.m. - 10:00 p.m.
Montana State University - Billings
Billings

Region IV

August 8, 1994
7:00 p.m. - 10:00 p.m.
Yellowstone Motor Inn
Livingston

August 10, 1994
7:00 p.m. - 10:00 p.m.
Montana College of Mineral
Science and Technology
Butte

Region V

August 3, 1994
7:00 p.m. - 10:00 p.m.
KwaTaqNuk Resort
Polson

August 4, 1994
7:00 p.m. - 10:00 p.m.
Village Red Lion Inn
Missoula

IX. MONTANA HEALTH CARE AUTHORITY ACT
(SB 285)

MONTANA CODES ANNOTATED

TITLE 50

CHAPTER 4

MONTANA HEALTH CARE AUTHORITY

50-4-101. State health care policy. (1) It is the policy of the state of Montana to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary to develop a health care system that is integrated and subject to the direction and oversight of a single state agency. Comprehensive health planning through the application of a statewide health care resource management plan that is linked to a unified health care budget for Montana is essential.

(2) It is further the policy of the state of Montana that the health care system should:

(a) maintain and improve the quality of health care services offered to Montanans;

(b) contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income or the money available for other services required to ensure the health, safety, and welfare of Montanans;

(c) avoid unnecessary duplication in the development and offering of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(e) facilitate universal access to health sciences information;

(f) promote rational allocation of health care resources in the state; and

(g) facilitate universal access to preventive and medically necessary health care.

(3) It is further the policy of the state of Montana that regardless of whether or what form of a health care access plan is adopted by the legislature, the health care authority, health care providers, and other persons involved in the delivery of health care services need to increase their emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only services to the consumer that are reasonable and necessary.

50-4-102. Definitions. For the purposes of this chapter, the following definitions apply:

(1) "Authority" means the Montana health care authority created by 50-4-201.

(2) "Board" means one of the regional health care planning boards created pursuant to 50-4-401.

(3) "Certificate of public advantage" or "certificate" means a written certificate issued by the authority as evidence of the authority's intention that the implementation of a cooperative agreement, when actively supervised by the authority, receive state action immunity from prosecution as a violation of state or federal antitrust laws.

(4) "Cooperative agreement" or "agreement" means a written agreement between two or more health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care facilities.

(5) "Data base" means the unified health care data base created pursuant to 50-4-502.

(6) "Health care" includes both physical health care and mental health care.

(7) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

(8) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

(9) "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

(10) "Management plan" means the health care resource management plan required by 50-4-304.

(11) "Region" means one of the health care planning regions created pursuant to 50-4-401.

(12) "Statewide plan" means one of the statewide universal health care access plans for access to health care required by 50-4-301.

50-4-201. Montana health care authority -- allocation -- membership. (1) There is a Montana health care authority.

(2) The authority is allocated to the department of health and environmental sciences for administrative purposes as provided in 2-15-121.

(3) The authority consists of five voting members appointed by the governor. At least one member must represent consumer organizations. Members of the authority must be appointed as follows:

(a) Within 30 days of May 3, 1993, the speaker and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The speaker and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(b) Within 30 days of May 3, 1993, the president and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The president and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(c) Within 90 days of May 3, 1993, the governor shall appoint from those nominated under subsections (3)(a) and (3)(b) five individuals to the authority.

(4) A vacancy must be filled in the same manner as original appointments under subsection (3), except that one individual must be selected under subsection (3)(a) and one under subsection (3)(b). The governor shall appoint from those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and rehabilitation services and the department of health and environmental sciences and the commissioner of insurance are nonvoting, ex officio members of the authority.

(8) The attorney general is an ex officio, nonvoting member of the authority only for the purpose of the authority's approval or denial of certificates of public advantage, supervision of cooperative agreements, and revocation of certificates of public advantage pursuant to Title 50, chapter 4, part 6.

(9) A member shall acknowledge a direct conflict of interest in a proceeding in which the member has a personal or financial interest.

50-4-202. Administration of health care authority -- reports -- compensation. (1) The authority shall employ a full-time executive director who shall conduct or direct the daily operation of the authority. The executive director is exempt from the application of 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 2-18-1013 and serves at the pleasure of the authority. The executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the authority.

(2) The authority may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. However, the authority may not delegate its rulemaking powers under Title 50, chapter 4, parts 1 through 5.

(3) The authority may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The authority may:

(a) apply for and accept gifts, grants, or contributions from any person for purposes consistent with 50-1-201 and Title 50, chapter 4, parts 1 through 5;

(b) adopt rules necessary to implement Title 50, chapter 4, parts 1 through 5; and

(c) enter into contracts necessary to accomplish the purposes of Title 50, chapter 4, parts 1 through 5.

(5) The authority shall report to the legislature and the governor at least twice a year on its progress since the last report in fulfilling the requirements of Title 50, chapter 4, parts 1

through 5. Reports may be provided in a manner similar to 5-11-210 or in another manner determined by the authority.

(6) Members of the authority must be paid and reimbursed as provided in 2-15-124.

(7) The authority shall make grants to the boards for the operation of the boards. The authority shall provide for uniform procedures for grant applications and budgets of the boards.

50-4-301. Statewide universal access plans required. (1) On or before October 1, 1994, the authority shall submit a report to the legislature that contains the authority's recommendation for a statewide universal health care access plan based on a single payor system and a recommendation for a statewide universal access plan based on a regulated multiple payor system. Each statewide plan must contain recommendations that, if implemented, would provide for universally accessible, medically necessary, and preventive health care by October 1, 1995. Both plans must be voted on by the 1995 legislature. The legislature may return one or both plans to the authority for further development.

(2) For purposes of this section:

(a) a single payor system is a method of financing health care services predominantly through public funds so that each resident of Montana receives a uniform set of benefits as established through statute or administrative rule. Policies governing all aspects of the management of the single payor system would reside with state government, and benefits must be administered by a single entity.

(b) a regulated multiple payor system is a method of financing health care services through a mix of public and private funds so that each resident of Montana receives a uniform set of benefits as established by statute or administrative rule. State government has responsibility for regulating the multiple entities that provide benefits to residents, including regulations for enrollment, change in premium rates, payment rates to providers, and aggregate health expenditures.

50-4-302. Features of statewide plans. (1) Each statewide plan under 50-4-301 must contain the features required by 50-4-303 through 50-4-306 and this section.

(2) Each statewide plan must include:

(a) guaranteed access to health care services for all residents of Montana;

(b) a uniform system of health care benefits;

(c) a unified health care budget;

(d) portability of coverage, regardless of job status;

(e) a broad-based, public or private financing mechanism to fund health care services;

(f) consideration of the limitations of public funding;

(g) a system capped for provider expenditures;

(h) global budgeting for all health care spending;

(i) controlled capital expenditures;

(j) a binding cap on overall expenditures;

(k) policymaking for the system as a whole and accountability within state government;

(l) incentives to be used to contain costs and direct resources;

(m) administrative efficiencies;

(n) the appropriate use of midlevel practitioners, such as physician's assistants and nurse practitioners;

(o) mechanisms for reducing the cost of prescription drugs, both as part of and as separate from the uniform benefit plan;

(p) integration, to the extent possible under federal and state law, of benefits provided under the health care system with benefits provided by the Indian health service and the United States department of veteran affairs and benefits provided by the medicare and medicaid programs; and

(q) an actuarially sound estimate of the costs of implementing the plan through the year 2005.

(3) Nothing in 50-4-303 through 50-4-306 or this section may be interpreted to prevent Montana residents from seeking health care services not provided in either or both statewide plans.

50-4-303. Cost containment. (1) The statewide plans must contain a cost containment component, including annual cost containment targets. Except as otherwise provided in this section, each statewide plan must establish targets for cost containment so that by 1999, the annual average percentage increase in statewide health care costs does not exceed the average annual percentage increase in the gross domestic product, as determined by the U.S. department of commerce, for the 5 preceding years.

(2) The authority shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the targets required in subsection (1), including such factors as population increases or decreases, demographic changes, costs beyond the control of health care providers, and other factors that the authority considers significant.

(3) The authority shall, at a minimum, include the following features in the cost containment component:

(a) global budgeting for all health care spending;

(b) a system for limiting demand of health care services and controlling unnecessary and inappropriate health care. The system may include prioritization of services that allows for consideration of an individual patient's prognosis.

(c) a system for reimbursing health care providers for services and health care items. The reimbursement system must provide that all payors, public or private, pay the same rate for the same health care services and items and that reimbursement for services is based predominantly upon the health care service provided rather than upon the discipline of the health care provider.

(d) a method of monitoring compliance with the targets required in subsection (1);

(e) expenditure targets for health care providers and facilities;

(f) disincentives for exceeding the targets established pursuant to subsection (3)(e), including reduction of reimbursement levels in subsequent years;

(g) reimbursement of health care providers and health care facilities that is based upon negotiated annual budgets or fees for services; and

(h) a plan by the authority, health care providers, health insurers, and health care facilities to educate the public concerning the purpose and content of the statewide plans.

50-4-304. Health care resource management plan. (1) Each statewide plan must contain a health care resource management plan that takes into account the provisions of 50-4-303. The management plan must provide for the distribution of health care resources within the regions established pursuant to 50-4-401 and within the state as a whole, consistent with the principles provided in subsection (2).

(2) The management plan must include:

(a) a statement of principles used in the allocation of resources and in establishing priorities for health services;

(b) identification of the current supply and distribution of:

(i) hospital, nursing home, and other inpatient services;

(ii) home health and mental health services;

(iii) treatment services for alcohol and drug abuse;

(iv) emergency care;

(v) ambulatory care services, including primary care resources;

(vi) nutrition benefits, prenatal benefits, and maternity care;

(vii) human resources;

(viii) health sciences library resources and services;

(ix) major medical equipment; and

(x) health screening and early intervention services;

(c) a determination of the appropriate supply and distribution of the resources and services identified in subsection (2)(b) and of the mechanisms that will encourage the appropriate integration of these services on a local or regional basis. To arrive at a determination, the authority shall consider the following factors:

(i) the needs of the statewide population, with special consideration given to the development of health care services in underserved areas of the state;

(ii) the needs of particular geographic areas of the state;

(iii) the use of Montana facilities by out-of-state residents;

(iv) the use of out-of-state facilities by Montana residents;

(v) the needs of populations with special health care needs;

(vi) the desirability of providing high-quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; and

(vii) the cost impact of these resource requirements on health care expenditures;

(d) a component that addresses health promotion and disease prevention and that is prepared by the department of health and environmental sciences in a format established by the authority;

(e) incentives to improve access to and use of preventive care; primary care services, including mental health services; and community-based care;

(f) incentives for healthy lifestyles;

(g) incentives to improve access to health care in underserved areas, including:

(i) a system by which the authority may identify persons with an interest in becoming health care professionals and provide or assist in providing health care education for those persons; and

(ii) tax credits and other financial incentives to attract and retain health care professionals in underserved areas; and

(h) a component that addresses integration of the plan, to the extent allowed by state and federal law, with services provided by the Indian health service and by the United States department of veterans affairs and by the medicare and medicaid programs.

(3) In adopting the management plan, the authority shall consider the regional health resource plans recommended by regional panels.

(4) The management plan must be revised annually in a manner determined by the authority.

(5) Prior to adoption of the management plan, the authority shall hold one or more public hearings for the purpose of receiving oral and written comment on a draft plan. After hearings have been concluded, the authority shall adopt the management plan, taking comments into consideration.

50-4-305. Health care billing simplification. (1) Each statewide plan must contain a component providing for simplification and reduction of the costs associated with health care billing. In designing this component, the authority may consider:

(a) conversion from paper health care claims to standardized electronic billing; and

(b) creating a claims clearinghouse, consisting of a state agency or private entity, to receive claims from all health care providers for compiling, editing, and submitting the claims to payors.

(2) The health care billing component must include a method to educate and assist health care providers and payors who will use any health care billing simplification system recommended by the authority.

(3) The billing component must provide a schedule for a phasein of any health care billing simplification system recommended by the authority. The schedule must relieve health care providers, payors, and consumers of undue burdens in using the system.

50-4-306. Other matters to be included in statewide plans. (1) The statewide plans recommended by the authority must include:

(a) stable financing methods, including sharing of the costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phasein of the various components of the plans.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

(i) conduct a study of a system for reducing the use of defensive medicine by adopting practice protocols that would give providers guidelines to follow for specific procedures;

(ii) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

(iii) propose any changes, including legislation, that it considers necessary, including measures for compensating victims of tortious injuries.

(b) As part of its study under subsection (2)(a)(ii), the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be included in its report containing the statewide plans.

(3) The authority shall conduct a study of the impacts of federal and state antitrust laws on health care services in the state and make recommendations, including legislation, to address those laws and impacts. The authority may include in its plans legislation in addition to Title 50, chapter 4, part 6, that will enable health care providers and payors, including health insurers and consumers, to negotiate and enter into agreements when the agreements are likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. In proposing appropriate legislation concerning antitrust laws, the authority shall provide appropriate conditions, supervision, and regulation to protect against private abuse of economic power.

(4) The authority shall apply for waivers from federal laws necessary to implement recommendations of the authority enacted by the legislature and to implement those recommendations not requiring legislation.

50-4-307. Availability of plans -- hearings on statewide plans. (1) The authority shall make copies of the draft statewide plans widely available at public expense to interested persons and groups.

(2) The authority shall seek public comment on the development of each statewide plan required under 50-4-301. In seeking public comment on the development of the authority's recommendations for each plan, the authority shall provide extensive, multimedia notice to the public and hold at least one public hearing in each of the health care planning regions established by 50-4-401. The hearings must take place before the authority's report is submitted to the legislature. The authority shall consult with health care providers in the development of its recommendations for each statewide plan.

(3) The authority shall consider oral and written public comments on the statewide plans before recommending them to the legislature.

50-4-308. State purchasing pool -- reports required. (1) On or before December 15, 1994, and December 15, 1996, the authority shall report to the legislature on establishment of a state purchasing pool, including the number and types of groups and group members participating in the pool, the costs of administering the pool, the savings attributable to participating groups from the operation of the pool, and any changes in legislation considered necessary by the authority.

(2) On or before December 15, 1996, the authority shall report to the legislature its recommendations concerning the feasibility and merits of authorizing the authority to act as an insurer in pooling risks and providing benefits, including a common benefits plan, to participants of the purchasing pool.

50-4-309. Study of prescription drug cost and distribution.

The authority shall conduct a study of the cost and distribution of prescription drugs in this state. The study must consider the feasibility of various methods of reducing the cost of purchasing and distributing prescription drugs to Montana residents. The study must include the feasibility of establishing a prescription drug purchasing pool for distribution of drugs through pharmacists

in this state. The results of the study, including the authority's recommendations for any necessary legislation, must be reported to the legislature by December 1, 1996. If the authority determines that feasible methods are available without need for legislation or appropriations, the authority shall implement that part or those parts of its recommendations.

50-4-310. Long-term care study and recommendations. (1) The authority shall conduct a study of the long-term care needs of state residents and report to the public and the legislature the authority's recommendations, including any necessary legislation, for meeting those long-term care needs. The report must be available to the public on or before September 1, 1996, after which the authority shall conduct public hearings on its report in each region established under 50-4-401. The authority shall present its report to the legislature on or before January 1, 1997.

(2) This section does not preclude the authority from recommending cost-sharing arrangements for long-term care services or from recommending that the services be phased in over time. The authority's recommendations must support and may not supplant informal care giving by family and friends and must include cost containment recommendations for any long-term care service suggested for inclusion.

(3) The authority's report must estimate costs associated with each of the long-term care services recommended and may suggest independent financing mechanisms for those services. The report must also set forth the projected cost to Montana and its citizens over the next 20 years if there is no change in the present accessibility, affordability, or financing of long-term care services in this state.

(4) The authority shall consult with the department of social and rehabilitation services in developing its recommendations under this section.

50-4-311. Study of certificate of need process. (1) The authority shall conduct a study of the certificate of need process established under Title 50, chapter 5, part 3. The study must determine whether changes in the certificate of need process are necessary or desirable in light of the authority's recommendation for a single payor health care system required by 50-4-301. The study must include consideration of the role, effect, and desirability of:

(a) maintaining the exemptions from the certificate of need process for hospitals and for offices of private physicians, dentists, and other physical and mental health care professionals; and

(b) maintaining the dollar thresholds for health care services, equipment, and buildings and for construction of health care facilities.

(2) The results of the study, including any recommendations for legislation and changes in an agency's policies or rules, must be reported to the legislature no later than December 1, 1994.

50-4-401. Health care planning regions and regional planning boards created -- selection -- membership. (1) There are five health care planning regions. Subject to subsection (2), the regions must consist of the following counties:

(a) region I: Sheridan, Daniels, Valley, Phillips, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River, and Carter;

(b) region II: Blaine, Hill, Liberty, Toole, Glacier, Pondera, Teton, Chouteau, and Cascade;

(c) region III: Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn;

(d) region IV: Lewis and Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park, Gallatin, Madison, and Beaverhead;

(e) region V: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli.

(2) (a) A county may, by written request of the board of county commissioners, petition the authority at any time to be removed from a health care planning region and added to another region.

(b) The authority shall grant or deny the petition after a public hearing. The authority shall give notice as the authority determines appropriate. The authority shall grant the petition if it appears by a preponderance of the evidence that the petitioning county's health care interests are more strongly associated with the region that the county seeks to join than with the region in which the county is located. If the authority grants the petition, the county is considered for all purposes to be part of the health care planning region as approved by the authority.

(3) Within each region, the authority shall establish by rule a regional health care planning board. Each board must include one member from each county within the region. The members on each board shall represent a balance of individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care. Each regional board should attempt to achieve gender balance.

(4) The authority shall, within 30 days of appointment of its members, propose by rule a procedure for selecting members of boards. The authority shall select the members for each board within 180 days of appointment of the authority, using the selection procedure adopted by rule under this subsection. Vacancies on a board must be filled by using the authority's selection process.

(5) Regional board members serve 4-year terms, except that of the board members initially selected, at least three members serve for 2 years, at least three members serve for 3 years, and at least three members serve for 4 years, to be determined by lot. A majority of each regional board shall select a presiding officer. The presiding officer initially selected must serve a 4-year term. Board members must be compensated and reimbursed in accordance with 2-15-124.

50-4-402. Powers and duties of boards. (1) A board shall:

(a) meet at the time and place designated by the presiding officer, but not less than quarterly;

(b) submit an annual budget and grant application to the authority at the time and in the manner directed by the authority;

(c) adopt procedures governing its meetings and other aspects of its day-to-day operations as the board determines necessary;

(d) develop regional health resource plans in the format determined by the authority that must address the health care needs of the region and address the development of health care services in underserved areas of the region and other matters;

(e) revise the regional plan annually;

(f) hold at least one public hearing on the regional plan within the region at the time and in the manner determined by the regional board;

(g) transmit the regional plan to the authority at the time determined by the authority;

(h) apply to the authority for grant funds for operation of the regional board and account, in the manner specified by the authority, for grant funds provided by the authority; and

(i) seek from public and private sources money to supplement grant funds provided by the authority.

(2) Regional boards may:

(a) recommend that the authority sanction voluntary agreements between health care providers and between health care consumers in the region that will improve the quality of, access to, or affordability of health care but that might constitute a violation of antitrust laws if undertaken without government direction;

(b) make recommendations to the authority regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by health care providers;

(c) undertake voluntary activities to educate consumers, providers, and purchasers and promote voluntary, cooperative community cost containment, access, or quality of care projects; and

(d) make recommendations to the department of health and environmental sciences or to the authority, or both, regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

(3) Each regional board may review and advise the authority on regional technical matters relating to the statewide plans required by 50-4-301, the common benefits package, procedures for developing and applying practice guidelines for use in the statewide plans, provider and facility contracts with the state, utilization review recommendations, expenditure targets, and uniform health care benefits and the impact of the benefits upon the provision of quality health care within the region.

50-4-501. Uniform claim forms and procedures. (1) The commissioner of insurance, after consultation with the authority, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system.

(2) The commissioner may contract with a private or public entity to administer and operate an electronic claims processing system. If the commissioner elects to contract for administration and operation of the system, the commissioner shall award a contract according to Title 18, chapter 4.

50-4-502. Health care data base -- information submitted -- enforcement. (1) The authority shall develop and maintain a unified health care data base that enables the authority, on a statewide basis, to:

(a) determine the distribution and capacity of health care resources, including health care facilities, providers, and health care services;

(b) identify health care needs and direct statewide and regional health care policy to ensure high-quality and cost-effective health care;

- (c) conduct evaluations of health care procedures and health care protocols;
- (d) compare costs of commonly performed health care procedures between providers and health care facilities within a region and make the data readily available to the public; and
- (e) compare costs of various health care procedures in one location of providers and health care facilities with the costs of the same procedures in other locations of providers and health care facilities.

(2) The authority shall by rule require health care providers, health insurers, health care facilities, private entities, and entities of state and local governments to file with the authority the reports, data, schedules, statistics, and other information determined by the authority to be necessary to fulfill the purposes of the data base provided in subsection (1). Material to be filed with the authority may include health insurance claims and enrollment information used by health insurers.

(3) The authority may issue subpoenas for the production of information required under this section and may issue subpoenas for and administer oaths to any person. Noncompliance with a subpoena issued by the authority is, upon application by the authority, punishable by a district court as contempt pursuant to Title 3, chapter 1, part 5.

(4) The data base must:

(a) use unique patient and provider identifiers and a uniform coding system identifying health care services; and

(b) reflect all health care utilization, costs, and resources in the state and the health care utilization and costs of services provided to Montana residents in another state.

(5) Information in the data base required by law to be kept confidential must be maintained in a manner that does not disclose the identity of the person to whom the information applies. Information in the data base not required by law to be kept confidential must be made available by the authority upon request of any person.

(6) The authority shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

50-4-503. Health insurer cost management plans. (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the authority no later than January 1, 1994.

(b) The authority may use plans filed under this section in the development of a unified health care budget.

(2) The plans required by this section must be developed in accordance with standards and procedures established by the authority.

(3) The provisions of this section do not apply to dental insurance.

50-4-601. Finding and purpose. The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements among health care facilities. The purpose of this part is to provide the state, through the authority, with direct supervision and control over the

implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws.

50-4-602. Cooperative agreements allowed. A health care facility may enter into a cooperative agreement with one or more health care facilities.

50-4-603. Certificate of public advantage -- standards for certification -- time for action by authority. (1) Parties to a cooperative agreement may apply to the authority for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed agreement, a description of the scope of the cooperation contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The authority shall hold a public hearing on the application for a certificate before acting upon the application. The authority may not issue a certificate unless the authority finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the authority denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the authority not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The authority shall deny the application for a certificate or issue a certificate within 90 days of receipt of a completed application.

50-4-604. Reconsideration by authority. (1) If the authority denies an application and refuses to issue a certificate, a party to the agreement may request that the authority reconsider its decision. The authority shall reconsider its decision if the party applying for reconsideration submits the request to the authority in writing within 30 calendar days of the authority's decision to deny the initial application.

(2) The authority shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The authority shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the authority must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration.

50-4-605 through 50-4-608 reserved.

50-4-609. Revocation of certificate by authority. (1) The authority shall revoke a certificate previously granted by it if the authority determines that the cooperative agreement is

not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the authority without giving notice and an opportunity for a hearing before the authority as follows:

(a) Written notice of the proposed revocation must be given to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the authority within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the authority shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the authority, the agreement for which the certificate was issued is terminated.

50-4-610. Appeal. A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the authority to deny an application for a certificate or a decision by the authority to revoke a certificate. A revocation of a certificate pursuant to 50-4-609 does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts.

50-4-611. Record of agreements to be kept. The authority shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to this part. A party to a cooperative agreement who terminates the agreement shall notify the authority in writing of the termination within 30 days after the termination.

50-4-612. Rulemaking. The authority shall adopt rules to implement this part. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by this part, and appeals; and

(3) to effect the active supervision by the authority of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for which a certificate is in effect.

MONTANA CODES ANNOTATED

TITLE 50

CHAPTER 1 (Excerpt)

50-1-201. (Temporary) Administration of state health plan. The department is hereby established as the sole and official state agency to administer the state program for comprehensive health planning and is hereby authorized to prepare a plan for comprehensive state health planning. The department is authorized to confer and cooperate with any and all other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The department, while acting in this capacity as the sole and official state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the sole and official state agency to accept, receive, expend, and administer any and all funds which are now available or which may be donated, granted, bequeathed, or appropriated to it for the preparation and administration and the supervision of the preparation and administration of the comprehensive state health plan.

50-1-201. (Effective July 1, 1996) Administration of state health plan. The Montana health care authority created in 50-4-201 is the state agency to administer the state program for comprehensive health planning and shall prepare a plan for comprehensive state health planning. The authority may confer and cooperate with other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The authority, while acting in this capacity as the state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the state agency to accept, receive, expend, and administer funds donated, granted, bequeathed, or appropriated to it for the preparation, administration, and supervision of the preparation and administration of the comprehensive state health plan.

MONTANA CODES ANNOTATED

TITLE 33

CHAPTER 22

PART 18

SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

33-22-1801. (Effective January 1, 1994) Short title. This part may be cited as the "Small Employer Health Insurance Availability Act".

33-22-1802. (Effective January 1, 1994) Purpose. This part must be interpreted and construed to effectuate the following express legislative purposes:

- (a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;
- (b) to prevent abusive rating practices;
- (c) to require disclosure of rating practices to purchasers;
- (d) to establish rules regarding renewability of coverage;
- (e) to establish limitations on the use of preexisting condition exclusions;
- (f) to provide for the development of basic and standard health benefit plans to be offered to all small employers;
- (g) to provide for the establishment of a reinsurance program; and
- (h) to improve the overall fairness and efficiency of the small employer health insurance market.

(2) This part is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

33-22-1803. (Effective January 1, 1994) Definitions. As used in this part, the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of 33-22-1809, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group disability insurance, excluding the state group benefits plan provided for in Title 2, chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to 33-22-1812.

(6) "Board" means the board of directors of the program established pursuant to 33-22-1818.

(7) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(8) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claims experience, health status, and duration of coverage are not case characteristics for purposes of this part.

(9) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

(10) "Committee" means the health benefit plan committee created pursuant to 33-22-1812.

(11) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined to be a dependent in the health benefit plan covering the employee.

(12) "Eligible employee" means an employee who works on a full-time basis and who has a normal workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this

state, within which the carrier is authorized to provide coverage.

(14) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

(15) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual meets each of the following conditions:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(20) "Program" means the Montana small employer health reinsurance program created by 33-22-1818.

(21) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

(22) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to 33-22-1819.

(24) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(25) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

(b) are eligible to file a combined tax return for purposes of state taxation; or

(c) are members of an association that:

(i) has been in existence for 1 year prior to January 1, 1994;

(ii) provides a health benefit plan to employees of its members as a group; and

(iii) does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group.

(26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(27) "Standard health benefit plan" means a health benefit plan developed pursuant to 33-22-1812.

33-22-1804. (Effective January 1, 1994) Applicability and scope. This part applies to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) a portion of the premium or benefits is paid by or on behalf of the small employer;

(2) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

33-22-1808. (Effective January 1, 1994) Establishment of classes of business. (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs that are related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

(b) The small employer carrier has acquired a class of business from another small employer carrier.

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of 33-22-501(2).

(2) A small employer carrier may establish up to nine separate classes of business under subsection (1).

(3) The commissioner shall adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the case of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

33-22-1809. (Effective January 1, 1994) Restrictions relating to premium rates.(1) Premium rates for health benefit plans under this part are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business:

(i) the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate; or

(ii) if the Montana health care authority established by 50-4-201 certifies to the commissioner that the cost containment goal set forth in 50-4-303 is met on or before January 1, 1999, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage may not vary from the index by more than 20% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of

the employees or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage.

(f) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; and

(ii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(g) A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(h) For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

(i) The commissioner shall adopt rules to implement the provisions of this section and to ensure that rating practices used by small employer carriers are consistent with the purposes of this part, including rules that ensure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences because of the nature of the groups.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class

of business without regard to case characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection

(1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of the following:

(a) the extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or upon the actual or expected variation in health status of the employees of small employers and the employees' dependents;

(b) the provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claims experience, that affect changes in premium rates;

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions relating to any preexisting condition.

(5)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of this part and except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

33-22-1810. (Effective January 1, 1994) Renewability of coverage.(1) A health benefit plan subject to the provisions of this part is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

(b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;

- (c) noncompliance with the carrier's minimum participation requirements;
- (d) noncompliance with the carrier's employer contribution requirements;
- (e) repeated misuse of a restricted network provision;
- (f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:
 - (i) provide advance notice of this decision under this subsection (1)(f) to the commissioner in each state in which it is licensed; and
 - (ii) at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the affected small employers.
- (g) the commissioner finds that the continuation of the coverage would:
 - (i) not be in the best interests of the policyholders or certificate holders; or
 - (ii) impair the carrier's ability to meet its contractual obligations.
- (2) If the commissioner makes a finding under subsection (1)(g), the commissioner shall assist affected small employers in finding replacement coverage.
- (3) A small employer carrier that elects not to renew a health benefit plan under subsection (1)(f) is prohibited from writing new business in the small employer market in this state for a period of 5 years from the date of notice to the commissioner.
- (4) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section apply only to the carrier's operations in that service area.

33-22-1811. Availability of coverage -- required plans.(1)(a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b)(i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in

that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) The provisions of this section are effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation.

(2)(a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively than 33-22-110, except that the condition may be excluded for a maximum of 12 months.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d)(i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e)(i) If a small employer carrier offers coverage to a small employer, the small employer

carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4)(a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition.

33-22-1812. Health benefit plan committee -- recommendations. (1) The commissioner shall appoint a health benefit plan committee. The committee is composed of the following members:

(a) one health care provider;

(b) one representative of the health insurance industry;

(c) one employee of a small employer;

(d) one member of a labor union; and

(e) one representative of the general public who may not represent the persons or groups listed in subsections (1)(a) through (1)(d).

(2) The committee shall, after holding a public hearing, recommend the form and level of coverages to be made by small employer carriers pursuant to 33-22-1811.

(3)(a) The committee shall recommend benefit levels, cost-sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan that contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(b) The plans recommended by the committee must include cost containment features, such as:

(i) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(ii) case management;

- (iii) selective contracting with hospitals, physicians, and other health care providers;
- (iv) reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and
- (v) other managed care provisions.

(c) The committee shall submit the health benefit plans described in subsections (3)(a) and (3)(b) to the commissioner within 180 days after the appointment of the committee. The commissioner shall adopt as a rule pursuant to Title 2, chapter 4, part 3, the health benefit plans required by 33-22-1811(1) to be offered in this state.

33-22-1813. (Effective January 1, 1994) Standards to ensure fair marketing.(1) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage other than the basic or standard health benefit plans to a small employer on the basis of claims experience of the small employer or the health status or claims experience of its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

(2)(a) Except as provided in subsection (2)(b), a small employer carrier or producer may not directly or indirectly engage in the following activities:

(i) encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3)(a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.

(8) The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9)(a) A violation of this section by a small employer carrier or a producer is an unfair trade practice under 33-18-102.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier.

33-22-1814. (Effective January 1, 1994) Restoration of terminated coverage. The commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after January 1, 1994, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after July 1, 1993. The commissioner may prescribe the terms for the reissuance of coverage that the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

33-22-1818. Small employer carrier reinsurance program -- board membership.(1) There is a nonprofit entity to be known as the Montana small employer health reinsurance program.

(2)(a) The program must operate subject to the supervision and control of the board. The board consists of nine members appointed by the commissioner plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

(b)(i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of business or in the practice of a profession. One member of the board must be a small employer who is not active in the health care or insurance fields. One member of the board must be a representative of the general public who is employed by a small employer and is not employed in the health care or insurance fields.

(ii) The initial board members' terms are as follows: one-third of the members shall serve a term of 1 year; one-third of the members shall serve a term of 2 years; and one-third of the members shall serve a term of 3 years. Subsequent board members shall serve for a term of 3

years. A board member's term continues until that member's successor is appointed.

(iii) A vacancy on the board must be filled by the commissioner. The commissioner may remove a board member for cause.

(3) Within 60 days of July 1, 1993, and on or before March 1 of each year after that date, each assessable carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued in this state in the previous calendar year.

33-22-1819. Program plan of operation -- treatment of losses exemption from taxation. (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(3) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and

(f) provide for any additional matters necessary for the implementation and administration of the program.

(4) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

(e) establish conditions and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d)(i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group health benefit plan in effect before January 1, 1994, may not

be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(6)(a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (6).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (6).

(c) The board periodically shall review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(7) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in 33-22-1809.

(8)(a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make

interim assessments against assessable carriers to fund claims incurred by the program. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed \$10.

(9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by this part may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

(10) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(11) The program is exempt from taxation.

(12) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation.

33-22-1820. Periodic market evaluation -- report. The board, in consultation with members of the committee, shall study and report at least every 3 years to the commissioner on the effectiveness of this part. The report must analyze the effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this part. The report may contain recommendations for market conduct or other regulatory standards or action.

33-22-1821. Waiver of certain laws. A law that requires the inclusion of a specific category of licensed health care practitioners and a law that requires the coverage of a health care service or benefit do not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to this part but do apply to a standard health benefit plan delivered or issued for delivery to small employers in this state pursuant to this part.

33-22-1822. Administrative procedure. The commissioner shall adopt rules in accordance with the Montana Administrative Procedure Act to implement and administer this part.

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